DRAFT LEGISLATION—THE VETERANS' HEALTH CARE AND RESEARCH AMENDMENTS OF 1991

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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CONTENTS

April 10, 1991

Page

Draft Legislation—The Veterans' Health Care and Research Amendments of 1991 1

OPENING STATEMENTS

Chairman Montgomery 1
  Prepared statement of Chairman Montgomery 39
Hon. John Paul Hammerschmidt 2
Hon. Tom Ridge 46
Hon. Joseph P. Kennedy, II 3
  Prepared statement of Congressman Kennedy 49
Hon. Chris Smith 51

WITNESSES

Buxton, Frank C., deputy director, national veterans affairs and rehabilitation commission, The American Legion 30
  Prepared statement of Mr. Buxton 97
Chobanian, Aram, M.D., Dean, University of Boston School of Medicine, appearing on behalf of the Association of American Medical Colleges 18
  Prepared statement of Dr. Chobanian 70
Cohen, Richard, M.D., professor of medicine and physiology, Boston University School of Medicine, and president, American Federation for Clinical Research 21
  Prepared statement of Dr. Cohen 78
Cullinan, Dennis M., assistant director, national legislative service, Veterans of Foreign Wars 27
  Prepared statement of Mr. Cullinan 82
Detre, Thomas, M.D., president, University of Pittsburgh Medical Center; and chairman, Advisory Committee for Health Research Policy of the Department of Veterans Affairs 16
  Prepared statement of Dr. Detre 63
Dupree, Clifton, associate legislative director, Paralyzed Veterans of America . 33
  Prepared statement of Mr. Dupree 114
Egan, Paul S., legislative director, Vietnam Veterans of America 31
  Prepared statement of Mr. Egan w/attachment 101
Gorman, David W., assistant national legislative director for medical affairs, Disabled American Veterans 28
  Prepared statement of Mr. Gorman 91
Holsinger, James W., Jr., M.D., Chief Medical Director, Department of Veterans Affairs; accompanied by Robert E. Coy, Deputy General Counsel 11
  Prepared statement of Dr. Holsinger 53
Hooser, David Van, Director, Medical Information Resources Management, Department of Veterans Affairs; accompanied by Daniel Maloney, director, Washington Information Systems; and Ruth Dayhoff, M.D., medical computer specialist 4

MATERIAL SUBMITTED FOR THE RECORD

Page

Statements:
- American Association of Dental Schools 123
- American Psychiatric Association 131
- Association of Professors of Medicine 135
- Nurses Organization of Veterans Affairs 126

Written committee questions and their response:
- Chairman Montgomery to Department of Veterans Affairs 140
- Hon. John Paul Hammerschimdt to Department of Veterans Affairs 145

DRAFT LEGISLATION—THE VETERANS' HEALTH CARE AND RESEARCH AMENDMENTS OF 1991

WEDNESDAY, APRIL 10, 1991

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:00 am., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Rowland, Harris, Kennedy, Patterson, Sangmeister, Long, Edwards of Texas, Brewster, Applegate, Hammerschmidt, and Smith.

Also Present: Representative Peterson.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. The subcommittee will come to order.

This morning we are taking up draft legislation covering a range of VA medical programs. Many of the provisions contained in the draft bill were passed by the House during the 101st Congress as part of H.R. 5740.

The intent of the draft legislation is to improve the delivery of health care and services to veterans. First, it would increase the VA's ability to recruit and retain needed medical professionals by enhancing the VA research program.

As stated by many witnesses at prior hearings, the opportunity to conduct research is what attracts many professionals to the VA. It would also expand VA's authority to establish child care programs.

The draft bill also breaks new ground in proposing legislation to establish a "shared procurement" program. That program would permit VA to jointly own and use costly medical equipment with community facilities. This program would allow the VA to address some of its equipment needs. It would also help stretch VA resources further by requiring half the funding for this equipment to come from outside sources.

In developing this draft legislation, we have been mindful of the pay-as-you-go requirements of the law. We have developed proposals that provide needed expansions in benefits for our veterans. Their cost would be offset by modest savings in administration of VA's dental program.

Our proposal also emphasizes two important areas we highlighted in our report to the Budget Committee. These are treatment of

PTSD and care for homeless veterans. I want to commend Mr. Ridge for his concern about the need to expand PTSD programs, and also Mr. Kennedy for his proposals for the homeless. I support the need for these programs.

However, I think we all agree that expansion of programs should not come at the expense of ongoing medical care needs. As we advised the Budget Committee, we want to see new dollars for VA health care, for needed new equipment, for more staffing to improve quality, and for state-of-the-art technology that you will see in a minute.

In talking about money from the Budget Committee, Mr. L.F. Payne, working with Mr. Panetta last night on the Budget Committee proposals, were able to add $50 million for health care over what the President had recommended. Thanks to the work of Mr. Stenholm and Mr. Parker, and especially L.F. Payne, who really went to the mat for that additional $50 million, that is a lot of help. We asked for an additional $100 million for medical care, but as you know, everything up here is compromised and we were able to get $50 million. It's pretty well locked in now that we will have that additional money.

What the Budget Committee has recommended is about $172 million over what the President's budget is for veterans' programs. We never get all the money we want, but we came out pretty well on it.

Before we receive the testimony on this draft legislation, I want the members of the subcommittee to see a demonstration of pioneering work the VA is doing here at our Washington VA Hospital. I will let them explain it. It combines advances in computer technology and programming. In other words, you will see how "X" rays and large slides or other images can be read by color monitors. So we are looking forward to that demonstration as soon as I cut my remarks off—and I'm going to do that. The statement is too long, Mr. Staff.

[Laughter.]

I would like to yield at this time to John Paul Hammerschmidt for any comments he would like to make, the ranking minority member on the subcommittee.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. Hammerschmidt. Thank you very much, Mr. Chairman.

I am pleased to join you and my distinguished colleagues as we prepare to hear testimony on this draft bill, the Veterans Health Care and Research Amendments of 1991. As we know, this package contains several fiscally responsible improvements for veterans' health care, and many of these provisions are similar to those contained in H.R. 5740, which many of us will remember was passed by the House in the 101st Congress, but it didn't receive consideration in the other body.

Mr. Chairman, as the VA medical system gears up to provide services for our Nation's newest veterans, it is imperative that we take steps to ensure that the VA medical system is prepared to meet the long-term needs of all of our Nation's veterans. I look forward to hearing the testimony before us today of our witnesses, and I look forward to seeing this demonstration.

I apologize to our witnesses, that I have three subcommittee meetings starting at 10 o'clock over in the Public Works and Transportation Committee, so I may not be here for the entire presentation. But I know that the knowledgeable insight of our witnesses will assist us in preparing a new legislative package.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

I would point out to the subcommittee that we have three panels this morning and we would certainly like to move right along on these panels. I appreciate the membership staying as long as they possibly can.

Also, today at 2 o'clock we will bring up one of our legislative bills, which will be the only bill brought up to date, and we will probably have a vote on that bill. But it will be rolled over until tomorrow. Tomorrow we will have two bills, the gold medal bills for General Schwarzkopf and General Powell, and we will probably have—I'm just guessing—three votes tomorrow. There are no votes today. Then tomorrow morning the committee will meet and mark up the reemployment bill that is coming out of Tim Penny's subcommittee, who will manage that bill.

It is now my privilege to have Mr. Dave Van Hooser, who heads the VA Medical Information Resources Management, to lead off the demonstration, and also to introduce those persons at the table.

Mr. Kennedy.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, II

Mr. KENNEDY. I have a brief opening statement, Mr. Chairman, that I would like to make.

Mr. MONTGOMERY. Okay.

Mr. KENNEDY. Mr. Chairman, I have to, as well as Mr. Hammerschmidt, attend a meeting at the Energy and Commerce Committee in a few minutes. But I wanted to mention a couple of things before I went down there.

First I want to commend you for inviting a very distinguished member from the Commonwealth of Massachusetts to testify at today's hearing. Dr. Chobanian is the Dean of Boston University School of Medicine and is a world-renowned specialist in hypertension and cardiovascular care.

I also understand that Dr. Richard Cohen from Boston University is here today to testify. I wanted to thank you and the members of the committee for listening to their important testimony. The way the budget battle is heating up, I wonder if we might have to keep both of those doctors down here to treat any casualties of the budget.

I also wanted to bring up a second issue that I would like to submit for the record. I was disappointed to learn that when the committee drafted the authorizing language for these programs they inserted language that basically is a "kiss of death" for both the homeless program and the PTSD program. As I understand, the language reads that if the appropriations for the medical care account and the medical administration account do not exceed the

President's budget request by $225 million, $7.5 million respectively, then these programs are not to be funded for this year.

I just learned that the Budget Committee marked up a budget yesterday that did not meet this criteria. Historically, the Appropriations Committee has come under the Budget Committee mark. Mr. Chairman, I hope there is room between now and markup to try to work these difficulties out.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. I thank the gentleman.

Any other comments? If not, you may proceed, Mr. Van Hooser.

STATEMENT OF DAVID VAN HOOSER, DIRECTOR, MEDICAL INFORMATION RESOURCES MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DANIEL MALONEY, DIRECTOR, WASHINGTON INFORMATION SYSTEMS CENTER, DEPARTMENT OF VETERANS AFFAIRS; AND RUTH DAYHOFF, M.D., MEDICAL COMPUTER SPECIALIST, DEPARTMENT OF VETERANS AFFAIRS

Mr. VAN HOOSER. Good morning, Mr. Chairman, and members of the committee. We appreciate this opportunity to demonstrate the integrated imaging project developed at the Washington, DC VA Medical Center.

Mr. Dan Maloney, Director of the VA Information Systems Center here in Washington, and his associate, Dr. Ruth Dayhoff, will conduct the demonstration today. Dr. Dayhoff has been the chief developer of this project and was recently given a prestigious Federal award for this effort.

Dan?

Mr. MALONEY. Thank you.

Today we would like to show you a state-of-the-art project on digitized medical imaging. It is a project which is unique in the world, and it is built upon standard, off-the-shelf components. This project is adding images into an existing hospital information system. Images are important because they are a large part of the clinical record. Their information content is very large and they are often very difficult to translate into words that other clinicians can review without loss.

Images are currently stored throughout the hospital. They are often missing when the physician needs to access them, and they are very difficult to get together in one location so that the clinician can get an integrated view of the patient's condition. The technology is currently to the stage where a project like this is now becoming possible.

We have a question of whether this will be the physician's desk of the future. It shows lots of terminals, from lots of different specialized imaging systems. We believe that a superior system would have one terminal for all imaging applications, that this would be much more cost-effective and a much more useful system.

The VA has distinct advantages of having one system at all but five VA medical centers. We have the largest single patient database in the world. This gives us a unique opportunity for innovative projects like the imaging project. Our system is built in such a way that all applications can access common information, no matter which system they are obtained from. The laboratory, the pharmacy, the radiology and the medicine application packages can all access a common database.

What we will be showing you today is a work station which has two terminals. It has one for text and the other for images. The images can be captured in a variety of ways, including off of a video camera, or from medical instruments that do obtain digital images, and we can transfer the files directly.

Any person wanting any image from any location in the hospital can obtain that image with a system like this. So pathology slides or cardiac catheterization slides can be obtained from an imaging work station anywhere in the facility. The physicians will not have to spend as much time running around looking for images. They will be able to spend their time treating the patients.

This gives you an overview of the locations that we are currently installing at the Washington VA Medical Center, including cardiology, intensive care units, and the pathology area.

The VA imaging system is a unique system, in that it integrates images into the existing hospital information system. We are capturing high resolution, full color images of various types, lot of different types of medical images. They will be able to be accessed from any work station in the medical center. This system is built upon inexpensive systems components and is designed for the treating physician.

At this point in time Dr. Ruth Dayhoff will show you some of the images which we have been working with.

[TV Monitor Presentation.]

Dr. DAYHOFF. What you see here on the two monitors is exactly what a doctor will see in the VA medical centers, except these monitors are larger. On one monitor we show the text data, which is currently part of the hospital information system, and it is exactly as they see it on a terminal today.

On the other monitor are images that are associated with that data. This is a sample medical record. This patient came in with some dark lesions on his back. You can see the true color image. This color is the color that is real. We can handle up to 16 million different colors on the monitors.

This is a close up of the patient's back. These are obtained with a video camera. You can see the good detail. The patient had a chest "X" ray done and it shows some large, round, white lesions, which suggests that he has a cancer. These lesions were biopsied and sent to the laboratory. The pathologist looked at them and this is what the pathologist saw through the microscope. This is a slightly higher power view through the microscope, and this is a very high power view. We can even see the detail inside the cells. We can see the chromosomes.

This is another patient that came in with some cough and some problems in breathing. This image was obtained through a bronchoscope, a device which allows the physician to pass a fiber optic tube into the patient's lungs to take a look at the problem.

This is another picture through the bronchoscope. We can see a little bleeding here. A biopsy was taken of this lesion, and again this is what the pathologist saw under the microscope. This is a higher power view, and we begin to see the detail inside the cells.

This is a very high power view. We can see that the chromosomes are dividing abnormally and this patient has a carcinoma.

You can also handle very high-resolution "X" rays. Here we see a full chest "X" ray. We can zoom in on particular areas and take a look in detail at those areas. Here we see a chest lead used to monitor the patient. You can see how we can zoom in. You may also notice it is very white at the bottom of this "X" ray. We can do a little manipulation of the image to let the physician see what is really in that area.

We are able to do this because we are dealing with digitized images rather than video images. It lets us manipulate the image. You can see there is actually a lead hiding down in there that we couldn't see at all before.

There is also important information in sequences of pictures. We can show a sequence here. These are nuclear medicine scans of the heart. What we are seeing is the blood flowing between the ventricles of the heart.

I think what we will do right now is show a videotape that we brought with us of the hospital system. This shows the physicians actually using the system to capture images. This will give you a better idea of how this fits into patient care.

[A 10-minute videotape presentation was shown.]

Mr. MALONEY. There are many benefits which we have seen so far for the integrated imaging project—rapid access to comprehensive patient data, various types of education—and as more images are gathered as part of the treatment of the patient, the research value will increase dramatically.

The digitized medical imaging project is considered to be part of the clinical practice extensions.

One area we look forward to getting involved with is Tele-Consultation, whereby images could be transmitted to other medical centers. This would allow consultation with physicians at other locations as well as allow sharing of expertise among VA medical centers.

There are many components which are uniquely available within the VA for a system like this. There is located at 169 medical centers an integrated DHCP hospital information system currently operating. We have a large organization of very talented people at those medical centers with proven track records.

An imaging system will be able to extend the capabilities of this information system into a new dimension. Some of these components provide the clinical team with support that is not available anywhere else in the world.

Mr. VAN HOOSER. Mr. Chairman, this concludes our demonstration. I would like to thank you and the members of the committee for your continuing support and encouragement for our health care automation projects in the VA. We would be pleased to answer your questions at this time.

Mr. MONTGOMERY. Thank you, Mr. Van Hooser. I think we were all impressed with that demonstration. I want to thank you and the staff, that we have capable people working in the VA medical system here at the Washington facility. We thank you for that very fine demonstration.

The bottom line is that we give better medical care and better diagnoses to the veterans by having this type of treatment. This is the only VA facility that has the opportunity to do something like this, is that correct, and the VA has not requested the funding to expand this to additional hospitals?

Mr. VAN HOOSER. This is currently the only medical center that has the system. We have plans for expanding the system to other sites, depending on the availability of funding in the future. But currently there is no funding provided to go beyond this one site.

Mr. MONTGOMERY. How did you get the funding?

Mr. VAN HOOSER. For the first site?

Mr. MONTGOMERY. Yes.

Mr. VAN HOOSER. It was programmed out of existing computer system development resources.

Mr. MONTGOMERY. In different regions, could they reprogram? This seems so important that they could reprogram funding, too.

Mr. VAN HOOSER. Perhaps that would be the case, if the Chief Medical Director and Secretary were in a position to do that. That hasn't been addressed at this time.

Mr. MONTGOMERY. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. When you reprogram, did this come out of R&D money or different pools of money?

Mr. VAN HOOSER. No, it was not research money. It came out of our regular ADP operating funds.

Mr. HAMMERSCHMIDT. What did it cost, about a million bucks?

Mr. VAN HOOSER. It's about a million dollars for an average size medical center. That includes the imaging work stations and personal computers that make up the work station. It also includes pulling fiber optic cable throughout the medical center to handle the images.

Mr. HAMMERSCHMIDT. If you put it in, say, 150 hospitals, or 172 hospitals, would that cost come down substantially?

Mr. VAN HOOSER. Yes, I believe it would. This equipment is essentially purchased off of the regular GSA schedule prices. Normally we would go out with an RFP. We have been fortunate to have discounts ranging between 40 and 60 percent, so we believe we could get that price down with a competitive procurement.

Mr. HAMMERSCHMIDT. It's very exciting. I'm glad we got to see that this morning. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Before yielding to Dr. Rowland, is this new in the medical field, that you can move this around in different parts of the hospital? Do private and public hospitals have this ability of using these types of systems, or is this something new?

Mr. VAN HOOSER. There are other examples of imaging systems installed in hospitals, but generally they are single-source systems; that is, they portray "X" ray images or images from a single source rather than the multiple image sources that we have shown.

Also, they generally do not use the off-the-shelf hardware products that we have used and are somewhat more proprietary and probably a little more expensive.

Mr. HAMMERSCHMIDT. Mr. Chairman, if I may, what does it cost to operate this? I know that's a pretty broad question. But if you use it extensively in a VA hospital, say yours, what does it cost to run something like this?

Mr. **Van Hooser**. I believe that would be hard to project. The additional computer operational cost, once it's installed, would be minimal. The same computer staff that are already running DHCP would be responsible for the routine operations. The other costs, of course, would be the professional clinician cost in looking at the screens and using it.

Mr. **Hammerschmidt**. That would just have to be allocated on a per patient use, I guess?

Mr. **Van Hooser**. Yes.

Mr. **Hammerschmidt**. Thank you.

Mr. **Montgomery**. Dr. Rowland.

Mr. **Rowland**. Thank you, Mr. Chairman.

I want to commend you for the innovation of this system, the collation of all of the information to arrive at a diagnosis much more quickly.

Let me ask you, what is the time lapse, for example, between a biopsy until you get the final pathological report?

Dr. **Dayhoff**. I think it's in an order of days, but I don't know how many days it takes to get a written report back.

Mr. **Rowland**. Let me rephrase that question.

You're doing the procedure and you're doing a biopsy and you need to get a pathological report to make a decision about whether or not to proceed with more extensive surgery. What is the time lapse in that instance?

Dr. **Dayhoff**. This is a case where you're not getting a frozen section and deciding right away, but you're——

Mr. **Rowland**. Does this system expedite that?

Dr. **Dayhoff**. Yes.

Mr. **Rowland**. That was my understanding. I wondered what the difference now would be.

Dr. **Dayhoff**. That certainly is the intention, that we will have one of these in the operating room, so that, in fact, we can get frozen section images back to the surgeons on the spot.

So far we have seen the images are in before the reports are in, so that actually for a conference it can be discussed before a written descriptive report is in the system.

Mr. **Rowland**. But you can provide that information for the surgeon much more rapidly with this system than you could with a frozen section and waiting and waiting until you get the report back on that?

Dr. **Dayhoff**. Yes.

Mr. **Rowland**. Is my question clear?

Mr. **Maloney**. Plus the fact that if there is a monitor in the room, the surgeon can actually see the image of the frozen section.

Dr. **Dayhoff**. And without leaving the operating room, either.

Mr. **Rowland**. But the pathologist can see that and advise the surgeon about what he needs to do?

Mr. **Maloney**. Yes, the pathologist could advise them, as they do now, over an intercom, a telephone type system. And if there was a monitor in the operating room, the surgeon could also see the image of the slide there.

Mr. **Rowland**. I don't mean to get off on a technical discussion, but I'm really intrigued by what you're able to do here.

Mr. **Montgomery**. Would the gentleman yield?

Mr. **Rowland**. Yes.

Mr. **Montgomery**. Sometimes you have a kind of skin cancer and so forth. They take it off your face and run it down to the pathologist and then you wait for 15 or 20 minutes. I assume the pathologist could show the cell back on this.

Mr. **Rowland**. That was my question. I wasn't particularly thinking about skin cancer but a procedure where you have a patient under anesthesia and you are able to move more rapidly with this. I see somebody in the back there shaking their head.

All right. Thank you very much, Mr. Chairman.

Mr. **Montgomery**. Any further comments? Mr. Applegate.

Mr. **Applegate**. Thank you, Mr. Chairman.

I was very intrigued with your system and all. I'm interested really in the reprogramming, which is an interesting phrase. Also, have you discussed your imaging setup with other hospitals within the VA system and have they shown an interest and shown a possibility ability to be able to also reprogram? I would be very interested in knowing about that.

Dr. **Dayhoff**. Well, I have a pile of messages on my desk from other hospitals that are interested in the system.

Mr. **Applegate**. I'll bet you do.

Dr. **Dayhoff**. Basically, they are all looking for ways that they can obtain the system.

Part of what happens is they have a certain amount of money one year and it may not be enough to make a large purchase. They might be able to gather up over consecutive years, but that doesn't really let us go out for bids and get the good prices that we could get.

Mr. **Applegate**. Do you take this out of a 1-year appropriation, then? Is that the idea? In other words, when you reprogram, you take it out of one year and you don't worry about anything in the future? In other words, you don't take it out of a period of years.

Mr. **Van Hooser**. What we have done for this prototype, to do the development, was to take it out of any money we could find in our ADP funds, operational funds. That does create a requirement to support it in subsequent years out of those same funds.

Mr. **Applegate**. Did you have an easier ability in adapting to this because of on-site facilities already that maybe other hospitals may not have?

Mr. **Van Hooser**. Well, all of the VA medical centers, except five, have this same DHCP system.

Mr. **Applegate**. All but five?

Mr. **Van Hooser**. All but five. The five that do not have it are the commercial IHS sites. So we have essentially the same hardware and the same ability to use this package that we have demonstrated today in all but five VA medical centers.

Mr. **Applegate**. Have the other hospitals shown an inclination to try to adopt this kind of reprogramming formula to do this?

Mr. **Van Hooser**. No, not to a large extent. For one thing, it has just been made public and shared with them, that this system exists. There have been some recent magazine articles and publications, professional demonstrations. They also understand that we have been requesting funding for this in future fiscal years, so that we could do it on a centrally-provided, procured basis.

Mr. **Applegate**. Is your reprogramming similar to the one we adopted in the 1991 budget? In other words, if you're going to expend moneys over here, you have to take it out of these other areas, and if you do, where do you take it from?

Mr. **Van Hooser**. Essentially we have taken it out of our maintenance and supply, the normal funding that we have for DHCP.

Mr. **Applegate**. It doesn't hurt the operation of the facility, obviously. Of course, with what you have added on really greatly weighs the positiveness of the whole system.

It's very interesting and I——

Mr. **Montgomery**. Dr. Holsinger is holding up his hand.

Dr. **Holsinger**. Yes. I would like to clarify what is being said.

Mr. **Montgomery**. Please come up to the microphone, and you might identify yourself, too, Dr. Holsinger.

Dr. **Holsinger**. I am Dr. Holsinger, the Chief Medical Director.

Congressman, the term is an incorrect term, to call it reprogramming. The funds that were used to purchase this were medical care appropriation dollars that are allocated to our medical information system. Those are funds that come to Mr. Van Hooser's operation to carry out our whole nationally organized Decentralized Hospital Computer Program.

Now, those funds are funds that are in his account, not the hospital's account. So this is not dollars that are taken from the hospital. In point of fact, Mr. Maloney is from the ISC, which is a regional center. It just happens to be located at the Washington, DC VA Medical Center. But they are on the staff of Mr. Van Hooser, not on the hospital staff. So they have provided this particular program as a pilot site using the Washington, DC hospital because they're located there.

But these funds have not come from the hospital and they have not been reprogrammed in the terms that we use from a fiscal point of view.

Mr. **Applegate**. Throwing the same question out, this could also very well apply to the other hospitals?

Dr. **Holsinger**. Right. And what Mr. Van Hooser is saying is that part of our clinical practice extension request, which was part of the Secretary's budget, included funds to begin the initial expansion of this project throughout a number of other VA medical centers. We would do that on a national contract so that we could get the lowest possible price to make it as cost effective as possible to put it into other VA medical centers.

The point I wanted to make was that we were not using reprogramming in a way that is not appropriate. These were funds that have come specifically through the medical care appropriation to support our Decentralized Hospital Computer Program nationwide.

Mr. **Applegate**. Thank you very much.

Mr. Chairman, I would just finish up by saying that I marvel at the technology that is available to us today. This just shows that so much can really be done and I commend you for moving forward and doing what you have done. I would just hope that in this great country of ours, with all of our economic resources—perhaps I shouldn't use that phrase, either—that every hospital should have this made available to them. Every veteran and every individual that's in a hospital in this country should have this kind of technology. Hopefully one day that will happen.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much, Doug.

I want to thank the panel. I think you can tell by the comments and questions how pleased we are that you're making this advancement.

I would suggest that you just leave your equipment there on the table because it does take some time to disassemble it.

I also believe that Dr. Barclay Shepard, who is retiring this month, has been working with you. He spent 33 years in the Navy and with the VA, and he has been a witness before this committee. I would like to have Dr. Shepard stand up and thank him for the good work he has done.

[Applause.]

You look mighty young to be retiring. So thank you all very much.

We will now ask our next panel to come forward, Dr. Holsinger and Mr. Coy.

STATEMENT OF JAMES W. HOLSINGER, JR., M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT E. COY, DEPUTY GENERAL COUNSEL

Dr. HOLSINGER. Good morning, Mr. Chairman. It's good to be here.

I have just a brief opening statement. We have the full statement which we will present for the record.

Mr. MONTGOMERY. Without objection.

Dr. HOLSINGER. Mr. Chairman and members of the committee, I am pleased to be here to provide the VA's views on various legislative proposals aimed at improving the VA health care system.

With me at the witness table is Mr. Robert Coy, the Deputy General Counsel of the VA. I want to thank you for including several VA proposals in your draft proposal.

We fully support the following proposals in the draft proposal:

First, the provision that would give the VA greater flexibility to establish and manage child care services for its employees.

Second, proposals that authorize limited outpatient dental work when it's necessary to prepare patients for admission to the hospital, and a proposal to raise the dollar threshold for requiring a second opinion for authorizing fee basis dental care.

Third, extension of VA's authority to contract with the Veterans Memorial Medical Center in the Philippines for care of U.S. veterans. The VA would recommend extending the authority for a full 5-year period, and likewise extend VA's authority to make grants to the government of the Philippines to assist in the maintenance of that facility.

Fourth, the proposal to establish education and licensure requirements for newly employed VA social workers.

Fifth, the proposal to require a 2-year minimum service obligation for participants in our health professional scholarship program.

Sixth, the proposal to extend by 1 year the authority of VA medical centers to establish independent, nonprofit research corporations and to extend by 1 year the period of time allowed for these corporations to attain tax exempt status. This authority has proven very beneficial to the VA research program and we recommend its continuation for a 5-year period. Since only 14 of the 54 corporations have achieved tax-exempt status, we also support the 1-year extension of time allowed to achieve this status.

Mr. Chairman, we also support your proposal that would make improvements to our advanced medical technology sharing program. Under this program, the VA shares the cost of procurement and installation and use of high-tech, high-cost equipment with institutions in the community. Your proposal would correct problems that have been identified during our early experience with this program.

We also support the intent of your provision to exempt the VA from regulation under the Clinical Laboratory Improvement Act Amendments of 1988. The application of these regulations to VA laboratory services will prove to be costly and we believe they are unnecessary. We are currently working with the Department of Health and Human Services to obtain an exemption from these regulations.

Mr. Chairman, your proposal for a pilot program directing research in specific areas, your proposal for specific additions to our PTSD treatment program, and your proposal for a new effort addressing the needs of homeless veterans are program initiatives that certainly address high-priority needs of the VA. I particularly want to thank you for recognizing that these initiatives should not be implemented within existing levels of resources.

Although we support the clinical goals of the proposals, we cannot support the specific provisions. Each of these proposals would have the effect of removing our flexibility to make decisions internally based upon assessment of the highest priority needs during the appropriate fiscal year. Clearly, if the level of resources envisioned by your proposals were to be received by the VA, based on the high priority of the clinical programs addressed, certainly some level of resources would accrue to these programs. However, we do not believe that legislative direction of funding priorities is in the best interest of the VA system as a whole.

Mr. Chairman, we also do not favor the amendments dealing with our major medical facility acquisitions program. We believe that your proposal would seriously impede our ability to effectively use advanced planning and design funds to develop projects to the point where they can be presented to the Congress. We also believe that these proposals will make our leasing program particularly difficult and less effective. However, we do support your proposal to enhance VA's authority to acquire and use real property or accept donated real property before Department of Justice approval of the title.

Mr. Chairman, this concludes my remarks. We would be pleased to respond to any questions you or other members of the subcommittee may have.

Than you.

[The prepared statement of Dr. Holsinger appears at p. 53.]

Mr. MONTGOMERY. Thank you very much, Doctor.

What is it in your testimony, as we consider marking up this bill, that you feel very strongly about?

Dr. HOLSINGER. Well, I believe there are certain things that would be obviously of great benefit for us. One is certainly the perspective of being able to attract, recruit and retain our staff in our hospitals, and certainly the child care provisions, would be exceptionally useful to us. I believe, also, that things that deal with dental benefits would have some significant use to us as well. Being able to take care of dental infections and major dental problems as outpatients, on patients that are coming in for surgery for other conditions, will certainly save us time and funds.

I believe one of the real major issues that we are facing is, of course, the issue of the clinical laboratories. It would be of major importance to us to have potentially some relief from that. We have entered into discussions with HHS to obtain exemption from the regulations, but I'm not sure that that is going to necessarily bear fruit or if it will bear fruit in the near term future. So I think your proposal would be of help to us on that point.

Mr. MONTGOMERY. Is that the CLIA regulations?

Dr. HOLSINGER. Yes, the Clinical Laboratory Improvement Act, CLIA. This is the one where we are attempting to obtain exemption from the HHS regulations, but it will be extremely costly and, we believe, an unnecessary burden upon our laboratories, which already have met Joint Commission Accreditation of Health Care Organizations review, plus the College of American Pathologists review. These new requirements have a start-up cost of approximately $80–82 million and an annual expenditure of around $75 million, which we believe would be counterproductive.

Mr. MONTGOMERY. I think we generally agree with you and that's in the legislation right now.

Dr. Rowland.

Mr. ROWLAND. If the gentleman would yield, I wanted to ask about CLIA.

Where are you, Dr. Holsinger, on getting an exemption? I know that we're going to have a terrible time in the private sector unless there is some relief given from the imposition of the regulations that may be imposed by CLIA. Where are you at this point in getting that exemption?

Dr. HOLSINGER. We are in the very earliest stages of attempting to obtain regulatory relief by way of HHS. As I said earlier, I'm not sure that that will bear fruit, and it may not bear fruit at all.

We believe that when you have a set of regulations, which I think received over 60,000 responses from across the country from all sectors, that obviously there is real concern about those. We believe it would have a major impact on our laboratory situation to go through with these new regulations.

Mr. ROWLAND. So you're not now exempt—For example, a dematologist that does KOH preparations in the VA now would not be able to do that?

Dr. HOLSINGER. Not as we currently do it.

Mr. ROWLAND. I'm really concerned about that, too.

Dr. HOLSINGER. It obviously has an impact, as you point out, not just in the VA but across the Nation's health care systems as a whole. But in our system, where we have rigid accreditation of our laboratories, both from the College of American Pathologists, the CAP, as well as the JCAHO. Plus we have a situation where the staff of our facilities, are Federal employees. Thus, we have a different level of control than would be the norm in the private sector.

Mr. ROWLAND. Do you think there is any concern about lowering the quality of care in the VA, that an exemption might lower the quality of care if you don't comply with CLIA?

Dr. HOLSINGER. Well, I don't think there would be any lowering of the quality of care, and I don't believe that by having the CLIA regulations in place in our hospitals would do anything to improve the quality of care in our hospitals.

Mr. ROWLAND. I certainly agree with you. I would appreciate it if you would sort of keep me informed about what's going on with that.

Mr. Chairman, I appreciate you yielding, and if you would yield just a little further, I would like to ask one other question about the child care.

I know they have a unit at DeKalb County at the VA in Atlanta that I was impressed with when I visited that hospital. How well is that child care unit doing there now? Do you know?

Dr. HOLSINGER. I do not have specific information of a current nature on that.

We have only a few locations where we have VA child care facilities, and we only have a relatively small number of children actually in place in those facilities. We need to be able to expand this. Utilizing the canteen, although they have worked hard at it, is probably not the most effective way for us to do this. We believe that your bill, including our request to do joint-venture type activities with the private sector, would give us a broad range of ability to impact on the child care problems.

Mr. ROWLAND. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Mr. Smith.

Mr. SMITH. Mr. Chairman, first of all I would ask that my opening statement be made a part of the record at the beginning of this hearing.

Mr. MONTGOMERY. Without objection, so ordered.

[The statement of Hon. Chris Smith appears at p. 51.]

Mr. SMITH. Doctor, how many graduates from the Health Care Scholarship Program leave VA employment after the minimum time of 1 year? You indicate that by supporting the 2-year minimum you might get some 14 months out of any given nurse who goes through the program.

Has that been tracked as to how many leave the service?

Dr. HOLSINGER. No, that has not been tracked. We are in the process of setting up a system that will allow us to do that. We are not currently able to obtain numbers that tell us the answer to your question.

We have several reasons, obviously, why we're interested in the 2 years versus the 1 year. It was originally 1 years and then it was changed legislatively to 1 year. But I personally believe that in exchange for what the individual receives in the scholarship program, the taxpayers basically deserve the benefit of having 2 years of service. I don't believe that is an onerous level. When we had a 2-year service obligation, we were able to attract the same quality of individuals we are attracting at the 1-year service obligation. We believe it would be, among other things, a much more cost-effective use of scholarship funds to be able to have a 2-year payback instead of a single year.

It does make a difference particularly in nursing. These are new graduates in most cases, straight from RN-producing programs, so they need not only to have the opportunity to develop their skills additionally under some direct supervision during the early days of their first employment, but they also need to become fully conversant with the way a particular hospital functions—whether it is ours or a private sector hospital makes no difference—and there is a certain period of time which it takes an RN to come fully up to speed.

We believe that, at one year, we're only getting 4 to 6 months of full use of that individual's skills. With the 2-year program, we would certainly have the ability to utilize those skills for a longer period of time.

Mr. SMITH. I would agree. The rationale seems very plausible and I would support that.

It would be helpful if we had some information as to the loss, the attrition rates.

Dr. HOLSINGER. We would agree with you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The Health Professional Scholarship Program's present data indicates a retention rate beyond obligated service of approximately 55 percent. The Program is presently planning to merge the Scholarship Program data base with the VA-PAID system. It is our projected plan to have the system running by the time we have completed our selection of new scholarship awardees (beginning of fiscal year 1992). This merging process will enable the Scholarship Program to track participants indefinitely throughout their VA careers.

Forty out of 1,261 participants terminated VA employment while in service obligation. This is a rate of only 3 percent.

Mr. SMITH. One other question, Mr. Chairman.

I understand from your testimony that you do not support the home improvement and structural alterations benefit increase. I wonder if you could tell us the last time that that benefit was increased.

Dr. HOLSINGER. Yes. That benefit was last increased in 1976.

Mr. SMITH. So we at least could make some argument that inflation in the ensuing years eroded that benefit somewhat?

Dr. HOLSINGER. That's correct, you could make that argument.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Chris.

Dr. Holsinger, we will have some questions that we will submit to you for you to answer in writing, so they can be put in the record. We thank you very much. You have a tough job out there and we look forward to seeing you again. I believe you're coming in next month to talk about some of the problems in the hospitals.

Dr. **Holsinger**. I appreciate being here. Thank you, Mr. Chairman.

Mr. **Montgomery**. Our next panel will be Dr. Thomas Detre—and I understand Dr. Detre has to catch a plane, so we will certainly let him leave whenever he would like to. And we have Dr. Aram Chobanian, who is from the Boston School of Medicine. Dr. Detre is from the University of Pittsburgh Medical Center. And Dr. Richard Cohen, President of the American Federation of Clinical Research and Professor of Medicine, also at the Boston University School of Medicine.

Go ahead, Dr. Detre.

STATEMENT OF THOMAS DETRE, M.D., PRESIDENT, UNIVERSITY OF PITTSBURGH MEDICAL CENTER; AND CHAIRMAN, ADVISORY COMMITTEE FOR HEALTH RESEARCH POLICY OF THE DEPARTMENT OF VETERANS AFFAIRS

Dr. **Detre**. Chairman Montgomery and members of the subcommittee, my name is Dr. Thomas Detre, and I am President of the University of Pittsburgh Medical Center.

It has been my privilege to chair Secretary Derwinski's Advisory Committee for Health Research Policy, and I am pleased to be here today to report to this subcommittee our findings in light of your draft legislation, the "Veterans' Health Care and Research Amendments of 1991."

Our Committee, made up of distinguished investigators, advocates and senior policy experts, was charged in January of 1990 to advise the Secretary whether VA research is appropriately balanced among subject areas, whether it is appropriate to the role of the VA in providing health care services to veterans, and whether it is complementary of the role of other Federal agencies, including NIH. In addition, we were asked to evaluate the overall quality of the VA research program and to recommend a research budget for fiscal year 1992.

We found the VA research program to be appropriately balanced, albeit inadequately supported. We urge the Secretary, in addition to provide an increased research allocation, and to consider adopting a recommendation made in a previous 1977 National Academy of Sciences review to appoint a Health Research Advisory Council. This Council would have representation from the preclinical, clinical, and other scientific disciplines relevant to VA research and serve to identify and prioritize areas of investigation. Topics we thought should be given early consideration were chronic obstructive pulmonary disease, hypertension, cancer therapy, cardiac disorders, chronic psychiatric disorders, substance abuse, and geriatrics.

In your draft legislation you are making a specific recommendation for increased funding for post traumatic stress disorder, a step which is eminently justified given our Nation's involvement in Operation Desert Storm. In this area, too, however, treatment programs should be backed up by rigorous research.

Our committee acknowledged that the post-World War II Federal initiative that encouraged VA medical centers to affiliate with medical schools has led to the development of a number of world-class VA medical centers which are capable of attracting, educating, and retaining superbly trained research-oriented physicians, as well as advancing the diagnosis and treatment of health problems among veterans.

The VA medical system is now the largest, most comprehensive health care system in the United States. VA medical centers have developed several landmark multicenter clinical trials and enhanced the quality of life of disabled veterans by improving prosthetic devices, sensory aids, and providing mobility assistance. For the future, they are ideally suited to look at chronic illnesses and other health problems affecting our increasingly aging population and destined to make important contributions to health policy decisions affecting not just the VA but the entire Nation.

With increasing competition for NIH extramural funding, the VA is an important source of support for M.D. researchers. The special strength of VA research lies in the high degree of physician involvement, which in no small measure is due to the fact that while NIH awards 75 percent of its funding to Ph.D. scientists who are less likely to be interested in clinical research, 75 percent of VA-funded researchers are M.D. scientists.

Our committee concluded that the quality of the VA research program is outstanding. This judgment is substantiated by the fact that research funding from sources outside the VA, especially NIH and ADAMHA, now nearly matches what is provided by the VA itself; by the fact that two VA investigators have received Nobel prizes; by the fact that 300 landmark publications have emanated from the Cooperative Studies Program's multicenter controlled clinical trials involving such diverse topics as coronary artery disease, hypertension, and schizophrenia; and by the fact that the VA's outstanding contributions to prosthetics, sensory aids and health services research have received worldwide recognition.

Since, over the past decade, medical schools have increasingly provided supplemental salary support for VA investigators and have fully integrated VA medical centers into their academic programs, the legislation you have proposed on shared instrumentation will be a very positive step to further consolidate these partnerships.

The new provisions for transfer possibility and shared title will make the role of the sharing partner more appealing, leading to the development of stronger research ties between medical schools and the VA and ultimately resulting in greater progress in the development of clinical treatments. Indeed, the University of Pittsburgh Medical Center just executed such a shared agreement for a Positron Emission Tomography, or PET, scanner with the VA to the great potential benefit of both parties concerned.

In making our budget recommendations to Secretary Derwinski, the members of the Advisory Committee for Health Research Policy were pleased to note the increase in funds allocated for health services research and rehabilitation research, which may be complemented in the future by enhanced funding for the priority areas identified by the Health Research Advisory Council.

Accordingly, while the committee recommended modest increases for rehabilitation research from $25.3 million to $28 million, and health services research from $15.3 to $17 million, we suggested that medical research should be increased substantially from $174.1 million to $235 million.

Mr. Chairman, I would like to thank you for allowing me this opportunity to present a very brief summary of the committee's main findings and recommendations and my comments on the Veterans' Health Care and Research Amendments of 1991. My detailed statement on these and other issues has already been submitted to you in writing.

Thank you.

[The prepared statement of Dr. Detre appears at p. 63.]

Mr. MONTGOMERY. Thank you very much, Dr. Detre. Your full statement will be put in the record.

Also for the record I want to thank our distinguished witnesses this morning for taking the time and working with us on our VA health care. We can't make it without the private and public hospitals and the professors and doctors like you giving us input and information. We probably have more problems in the medical care system right now than any other segment of health care, but we're going to get it straightened out. People like you coming in today will certainly help us.

What I would now like to do is recognize the other two witnesses and then have comments or questions from the other panel members.

Dr. Chobanian, we would be glad to hear from you, sir.

STATEMENT OF ARAM CHOBANIAN, M.D., DEAN, UNIVERSITY OF BOSTON SCHOOL OF MEDICINE, APPEARING ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. CHOBANIAN. Chairman Montgomery and members of the subcommittee, I am Aram Chobanian, Dean of the Boston University School of Medicine. It is a pleasure to appear before you this morning on behalf of the Association of American Medical Colleges to address the proposed "Veterans' Health Care and Research Amendments of 1991."

The AAMC serves as the national voice for the country's 126 accredited medical schools, over 90 professional and academic societies, and 420 major teaching hospitals, including 72 VA medical centers. Currently, 102 medical schools are affiliated with one or more VA facility. At my institution, we enjoy an affiliation with the Boston VA Medical Center at Jamaica Plain, and the Edith Nourse Rogers Veterans Memorial Hospital in Bedford, MA. The Boston VAMC is the major referral center and full-spectrum tertiary care hospital for veterans in New England. More than 100 resident physicians and a large number of medical students are assigned to this center. A Geriatric Research, Education, and Clinical Center is located at Bedford. In addition, the School of Medicine has major affiliations with Boston's Causeway Street Clinic and Lowell's outpatient clinics.

The AAMC recognizes the important role the VA plays in providing health care to a special group of Americans as well as educating future health care providers and developing new knowledge. Thus, the Association is pleased to participate in a dialogue to consider proposals to improve the system as well as to develop new programs to help the VA fulfill its overall mission.

While the proposed legislation under review today covers a variety of issues, I will limit my remarks to two sections that relate most directly to my professional interactions with VA operations, namely, the proposed research pilot program, and the proposal to enhance the VA's ability to enter into joint equipment purchases.

Academic medicine shares the view of this subcommittee and Dr. Detre's committee about the importance and special mission of the VA research program. The VA does, and should continue to, focus research resources primarily in the areas related to the health care needs of veterans. Clinical research, health services research, and rehabilitation research are key components of that program. Projects in each of these areas have led to advances with immediate benefits to veterans and have improved the quality of care delivered by the VA. For example, the VA is nationally recognized as a pioneer in the field of geriatrics, symbolized by the VA's GRECC program and the geriatric evaluation unit programs.

The involvement of Boston University with the Bedford VAMC clearly demonstrates the clinical advantages that are associated with medical research. The hospital's primary mission originally involved the long-term institutional care of psychiatric patients, but with our school's involvement and with the establishment of the GRECC at Bedford in 1975, this emphasis shifted to geriatric medicine. In 1976, the hospital established the first unit in the Nation dedicated to Alzheimer's disease. In this center, the relationship between research and clinical activities has been synergistic. The research activities associated with Alzheimer's disease have attracted physicians whose interests focus on the development of basic scientific knowledge as well as advancing clinical care. The research will have a significant impact on our understanding of Alzheimer's disease, its symptoms and its causes.

One current study is aimed at better understanding various forms of dementia, with a focus on Alzheimer's disease and the possibility that this disease might have several forms and causes. Another study is examining the effects on the brain of most disease processes, including seizures, mental retardation, strokes, head trauma, and degenerative diseases such as Huntington's disease and Alzheimer's disease. The basic information these studies provide has far-ranging implications for the treatment of several disease states.

The relationship between research and clinical care has been demonstrated again by continuing success in recruiting talented young physicians into the facility's program. More than 20 physicians have completed or are currently involved with the geriatric fellowship program.

Recently, a major center of excellence involved in the development of a new system of care for elderly patients has been funded at Bedford. Specific program components of the center of excellence include the establishment of a specialized hospital-based home care program, expansion of community residential care, establishment of an intensified ambulatory treatment center, development of an enhanced respite care program, utilization of the case management model in ambulatory care, and the creation of a veterans' community care center.

By no means is all research by our school faculty conducted at Bedford. Important projects relevant to the particular interests of this committee and related to the pilot program proposal are going on at the Boston VA as well. Of particular note is the Memory Disorders Research Center in Boston. The main purpose of the center is to study the relationship between memory disorders and brain injuries. Researchers are studying how and why memory is afflicted by diseases, including stroke, traumas, tumors and alcohol abuse. In addition to assessment and subsequent counseling for the veterans and their families, the center will provide appropriate therapies, including computerized procedures to help the veteran overcome memory disorder. Researchers at the Boston VAMC are also studying recovery patterns in diseases related to alcoholism.

At our school, we're proud of the contribution of our faculty to the care and research benefiting veterans at the excellent VA facilities with which we are affiliated. The enduring result of this relationship is the quality of care for a severely impaired veteran population and the training of young physicians committed to enhancing the delivery of care.

The AAMC has traditionally opposed designating funds for particular areas of research or specific projects because such an approach can limit the likelihood of funding for the grant proposals that are deemed most meritorious, based on the peer review process. However, the AAMC recognizes that some guidance is appropriate in outlining the general nature of a Federally-sponsored research effort. While the Association would object to a direct approach for the entire VA research program, we support the notion of prioritizing areas of investigations as a limited pilot program, if adequate funds are available, so long as the pilot program complements the underlying mission of the agency and the pilot program does not compete with the broad nature of the established program.

If I may, I would like to take a moment to thank the Chairman and members of the subcommittee for their advocacy on behalf of increased funding for the VA research program. To support your efforts, the AAMC and the coalition of organizations known as the "Friends of VA" will work with the Budget and Appropriations Committees to convey the message about the importance of providing an adequate budget for VA medical care and research.

Finally, the AAMC also supports, without modification, the proposal that would authorize the VA to procure medical equipment, title to which would be held jointly with any health care facility which provided VA with at least half the purchase price of that equipment, under arrangements where the parties have agreed to share in the use of such equipment.

Thank you, Mr. Chairman, for the opportunity to present my views on the Veterans' Health Care and Research Amendments. I will be happy to expand on any points addressed in my testimony or to comment on issues that I did not have time to address.

[The prepared statement of Dr. Chobanian appears at p. 70.]

Mr. MONTGOMERY. Thank you very much, Doctor.

I would like to say that we certainly depend on our medical school connections around the country. We realize on this committee, as well as the VA, that we really can't make it without the private medical schools and public medical schools working with our VA medical centers in the United States. It is so helpful that, if we were to lose that affiliation, then we would lose a good arm of the VA hospital care. So I guess we need you more than you need us, is what I mean to say.

Dr. Cohen.

STATEMENT OF RICHARD COHEN, M.D., PROFESSOR OF MEDICINE AND PHYSIOLOGY, BOSTON UNIVERSITY SCHOOL OF MEDICINE, AND PRESIDENT, AMERICAN FEDERATION FOR CLINICAL RESEARCH

Dr. COHEN. Chairman Montgomery and members of the subcommittee, my name is Richard Cohen. I am professor of medicine and research professor of physiology at Boston University School of Medicine, and the president of the American Federation for Clinical Research.

I am pleased to appear before this subcommittee to express the AFCR's views regarding fiscal year 1992 funding for VA health research. The AFCR is an organization of approximately 13,000 physician scientists, many of whom are based in VA hospitals, where they provide care to patients and receive support for their research. For the last several years, the AFCR has been concerned about the lack of adequate funding that the research program receives. This year, we are particularly concerned.

In January, a blue ribbon panel, commissioned by the Secretary of Veterans Affairs, and made up of distinguished scientists, economists and past policy makers, concluded after extensive study that the VA research program is inadequately funded. The panel found that the program does excellent research, greatly improves the care available to veterans, and is a crucial factor in the recruitment and retention of high-quality doctors to the VA. The panel also concluded that the research program "is inadequately supported to achieve its goals" and recommended a fiscal year 1992 budget of $280 million. The AFCR supports the panel's conclusions and would like to expand on several of its points.

As the blue ribbon panel points out, the "quality of VA research is exceptionally high" and "essential to provide the best care for veteran patients." The VA continues to uncover treatments and cures that both improve the health of veterans and save money for the VA and for our entire health care system. Recent accomplishments include the following:

A VA researcher recently found a way, using growth hormones, to control weight loss in the elderly, enabling them to fight osteoporosis and other age-related disorders. Addressing disorders of the elderly is crucial for the VA because the number of veterans over 65 will almost double in the next 30 years, reaching 7.7 million by the year 2020.

A recent VA conducted study uncovered a new treatment for chronic hepatitis B, a debilitating liver disorder which can be fatal. Treatment with interferon therapy halted or completely cured almost 40 percent of veterans treated. Each year, 60,000 veterans develop liver disorders.

A VA-sponsored study revealed that many veterans with prostate enlargement could be treated without surgery. Use of this nonsurgical procedure could save the VA up to $29 million annually.

Research at the VA showed veterans treated in geriatric evaluation units, facilities designed to improve hospital care for frail, elderly patients, have much lower mortality rates and fewer discharges to nursing homes than those given standard care. After establishing geriatric evaluation units in each of its hospitals, the VA predicts 200,000 fewer nursing home admissions annually, saving the VA $11 billion each year.

The VA research program continues to focus on those conditions that primarily affect veterans. Also, through the presence of a research program, veterans are given the opportunity to participate in cutting-edge therapies not yet available to the general public, such as the latest AIDS drugs and therapies to treat Alzheimer's disease.

Another crucial element of the research program is its ability to attract excellent physicians to VA hospitals. The VA, where the salaries, equipment, and overall environment are far below that in other care settings, is able to attract high-quality doctors by giving them the opportunity to conduct research as well as care for patients.

As the blue ribbon panel concluded in its report—and I quote: "Since the VA has a vigorous research program, which is essential to provide the best care for veteran patients, the system is able to attract a high-quality house staff and attending physicians. These two elements combined—the high quality staff and the research-driven care—enable the VA to provide superior services that could not be purchased in the private sector."

Unfortunately, as the panel's report points out, the program "is inadequately supported to meet its goals." As research opportunities diminish—only 40 percent of approved projects will be funded this year, compared to 80 percent funded in fiscal year 1985—many physicians have begun to question careers in the VA. In fact, the AFCR has learned of many physicians who, after years of being funded, are now denied support for their high-scoring projects due to severe budget constraints.

We have seen this situation all over the Nation, from California to Mississippi, to Massachusetts to Georgia. Physicians who have been in the VA for years and who are dedicated to finding better treatments to care for veterans can no longer get funding for their meritorious projects. After several years of this situation, these doctors have become extremely discouraged and are beginning to look elsewhere to pursue their careers. It will be a terrible state of affairs if veterans can no longer benefit from the superior care that these physicians offer.

In order to address the compounded problem of several years of underfunding, the blue ribbon panel recommended a fiscal year 1992 VA research budget of $280 million. This level would fund

1,840 research projects, 227 career development awards, and 26 cooperative studies—roughly the same number as were funded in 1985. The panel's recommendation of $280 million is not unrealistic because it would merely restore the research program to the level of effort provided in fiscal year 1985, before serious budget cuts took place.

Extensive study went into formulating these recommendations, developed by a panel specifically commissioned by the administration to examine the program. Therefore, we were surprised and dismayed that the very administration that asked for these recommendations appears to have ignored them. For fiscal year 1992, the Bush administration requests $216.8 million for VA research, $63 million less than the blue ribbon panel advised, and the same budget as appropriated in fiscal year 1991. We question why the panel was formed if its recommendations were not to be heeded. The AFCR supports the findings of the blue ribbon panel and hopes that Congress can see to it that they are followed. We thank the subcommittee for its longstanding interest in the VA research program.

With regard to the draft legislation, we are very pleased that it includes $43 million above the President's request for VA research. However, we are concerned that the proposed pilot program would direct the Secretary to single out research projects in the areas mentioned in the draft. The AFCR believes that priority should be given to those projects deemed the most worthy through the peer review process. We do not believe it is beneficial to target specific diseases or conditions and, on that basis alone, provide funding.

Thank you for considering the opinions of the American Federation for Clinical Research.

[The prepared statement of Dr. Cohen appears at p. 78.]

Mr. MONTGOMERY. Thank you very much, Dr. Cohen. I thank all three of our panelists.

Before I ask a few questions, we've had such excellent testimony that I would like the VA to be sure they had someone here today to hear this testimony.

Those from the VA downtown, will you stand up and identify yourselves so I can see how many are here.

[Members of VA staff in audience introduced.]

Mr. MONTGOMERY. They do listen to me. We have had several times here when there wasn't anybody here from the Veterans Department. I congratulate you. You ought to be here. Thank you for listening to this testimony. You're the folks who can get it done. I appreciate the Department being here and I will pass it on to the Secretary and pass it on to Dr. Holsinger.

Dr. Cohen, you mentioned the geriatric evaluation units that save money. Would you care to comment further on that?

Dr. COHEN. Only that the population of VA patients is increasing in age. That's a problem that needs to be addressed, and needs to be addressed now. These evaluation units are one way that the VA promises to pay back its research investment.

Mr. MONTGOMERY. I think that's one of our major problems, that even the Vietnam veteran is reaching the age of 60. Then you have those veterans from World War II and World War I.

The Alzheimer's patients, those are patients who are hard to treat. I'm really concerned, when I go into an Alzheimer's ward and see the problems that we have in our VA facilities, I would hope we could find a cure some day to help them out.

Dr. Chobanian.

Dr. **Chobanian**. I was just going to comment with relationship to both the Alzheimer's disease issue and the aging veteran population, that I think we need to be looking at new ways of providing health care for this population that just does not involve hospitalization. I think a complete spectrum of care, that can go from home care to include ambulatory services, and then only occasionally relate to hospitalizations for these patients with chronic diseases, such as Alzheimer's disease, will not only improve overall the quality of life of these individuals but it also will be saving a great deal of money. I think setting up these centers that can provide a continuum of care from the home through institutionalization will be extremely important.

Dr. **Detre**. Mr. Chairman, if I may make one comment on Alzheimer's disease. It is absolutely true that we can and should provide more humane care and support to the families who are equally victimized by this terrible disease.

The ultimate hope, however, lies in learning more about the central nervous system. We cannot separate the clinical agenda of taking care of patients from the intellectual agenda that ultimately leads to discoveries that are important. In fact, what little we already know about this disease is beginning to lead to the development of new memory-enhancing drugs.

I will not make an overall, optimistic statement that we could conquer Alzheimer's disease within the next 5 years, but certainly today, because of increased research funding both by NIH and ADHAMA and by the VA, there are a lot more studies going on in Alzheimer's disease than there would have been 15 years ago.

Mr. **Montgomery**. Thank you.

We have a state veterans' nursing home in my state that is about 4 or 5 years old now, and one of the problems we're having—we finally had to take just one ward and put 25 or 35 Alzheimer's patients in it. If you're not careful, your whole nursing home will end up with these types of patients. The state veterans' nursing home cannot handle them. It's a terrific problem.

Dr. Detre, you recommended—and maybe Dr. Cohen would want to comment on it. He was wondering why certain types of projects that you recommended be funded in the medical research program, and you said you do certain specialties. Would you care to comment on that, and then Dr. Cohen might make some comments.

Dr. **Detre**. Chairman Montgomery, actually our committee's findings and Dr. Cohen's statement overlap in many respects. I brought up some examples of areas which are frequently occurring clinical problems in an aging VA population, as we all recognize. In fact, we felt that maximum flexibility could be provided if the VA administration would adopt a recommendation from 1977, to set up an advisory council consisting of scientists who could advise the VA about what the priorities are and what would be the best way to utilize available funds. That, of course, is where the greatest promise lies. So actually, our two statements are nearly identical.

For instance, it is true that post traumatic stress disorder is going to increase now—at least it's quite likely that it's going to increase in our soldiers coming back from Desert Storm. But we do not know to what extent, and we don't have a clear idea of how much money is already spent on this topic. That is why we recommend, Mr. Chairman, that an advisory council should be continuously monitoring and identifying priority areas for the VA.

Mr. **Montgomery**. Thank you.

Dr. Cohen.

Dr. **Cohen**. Mr. Chairman, I would agree that an advisory council is how the VA system should approach directing its research.

It is a bit of a Pandora's Box. The VA has a relatively small research program compared to that of the NIH, and it might be a rather destructive thing to have to, every year, assign from this vantage point different groups' interests to the research program.

The other thing I would like to mention is the fact that I represent those young researchers doing research in the VA, and that process undermines the peer review process, which is part and parcel of the whole system of how research is funded in the VA as well as at NIH.

Mr. **Montgomery**. I want to thank you.

Dr. Chobanian, I have one question pertaining to your testimony about the sharing procurement concept. That is part of this bill that we're considering, about what it might hold for rural health care facilities. Would you further explain on rural health care or any other comments on sharing procurement?

Dr. **Chobanian**. I think the idea of sharing is a very good one, because it will help institutions that are currently unable to purchase the equipment to buy it, and also to be able to have a critical mass of use of such equipment. Although in the urban areas most hospitals have their own equipment and sharing probably is not necessary to a great extent, as we get out to smaller institutions and less populated areas, I think there is a major impact that sharing would have if individual medical centers, both VA and private, could get together to have centralized facilities for some major types of equipment.

Mr. **Montgomery**. What type of equipment would you give as an example?

Dr. **Chobanian**. Well, I think currently there are pieces of equipment that are important diagnostically, such as magnetic resonance imaging facilities, which would be in the multi-million dollar category. There are things called PET scanners, again which cost a great deal of money. I think it is generally in those large pieces of equipment where the major uses would be. It is just impossible for any single, small medical center to be able to purchase those.

Mr. **Montgomery**. This sharing agreement kind of overlaps. We have a sharing agreement with the Defense Department between our military and veterans hospitals. It has worked well. It has brought better medical care and it has cost the taxpayers less money, and we are able to treat more patients, both retirees, dependents, and veterans.

Are we doing much in the way of sharing agreements—and I'm not talking about equipment now—between the private hospital facilities, the public hospitals, on certain treatment and care? I'm not talking about the whole facility. Would someone care to follow up on that?

Dr. CHOBANIAN. Sure. I can give you some examples of how sharing is going on.

For example, some of our programs are combined between institutions, surgery programs, for example, the training of residents or providing residents with the VA facilities. We have one centralized program through the whole medical center, where both the university hospital at Boston, Boston City Hospital, and the Jamaica Plains Boston VA hospital will have joint oncology programs for cancer treatment, joint surgical training programs, joint medical training programs. I think to a great extent that many of the departmental services that are present within our medical school are shared between these institutions.

Dr. DETRE. Sharing goes one step further, as I mentioned. I would say in most instances now medical schools also provide supplemental salaries and/or earning opportunities because, actually, VA salaries, which used to be very competitive, unless they are further upgraded will have a difficult time matching the marketplace, so to speak. So most medical schools nowadays, Chairman Montgomery, do provide supplemental salaries or other means to assist in this integration process which has been described to you earlier.

Mr. MONTGOMERY. That's an excellent point.

Dr. Cohen.

Dr. COHEN. I simply wanted to add that the cooperation extends beyond patient care and includes research efforts that are joint. So that's another way that the combined medical center benefits the VA program.

Mr. MONTGOMERY. I want to thank you for your testimony, and maybe make this statement. There have been some rumors in the last couple of years that some day we would do away with the VA health care system. I don't think that will ever happen, not in my lifetime or your lifetime. In fact, we just made 220,000 more veterans in the Persian Gulf war. We have more patients than we've ever had before in the VA health care facilities. There is a place for health care out there, with our sharing agreements, the training facilities in both nursing and professional health care that comes through your hospitals and through our VA hospitals.

We've got all our bricks and mortar out there now and I doubt very much if we build any more big VA hospitals, but we will keep up with what we've got. We have a tremendous volunteer system that certainly saves a lot of money. The veterans' organizations, which will be testifying in a few minutes, are helping tremendously, and their auxiliaries and the veterans themselves of these organizations. They really save the taxpayers a lot of money.

I guess what I'm saying is VA health care is here for a long time and we need your help to make it work. Thank you very much to this distinguished panel of witnesses this morning.

Dr. DETRE. Thank you, Mr. Chairman.

Dr. CHOBANIAN. Thank you, sir.

Mr. MONTGOMERY. I would like to ask Mr. Peterson of Florida, a member of this committee, to take the chair for our last panel of witnesses. I appreciate very much him coming in and being chairman.

Mr. **Peterson** (presiding). Thank you very much, Mr. Chairman. Obviously, the quality of the chair is going to be reduced here a little bit, but I will try to make amends for that.

We appreciate your all coming today. As I was saying, I am very pleased and honored to sit in the chair of the Honorable Sonny Montgomery of Mississippi, an individual who I have idolized for many years. Perhaps you have, too, coming from the service organizations, where I have been a big participant in my career as well.

Today I would like to welcome Mr. Dennis Cullinan, the Assistant Director, National Legislative Service, Veterans of Foreign Wars, and who will actually speak first. Next is Mr. Frank Buxton, Deputy Director, National Veterans Affairs and Rehabilitation Commission of the American Legion; Mr. Cliff Dupree, Associate Legislative Director, Paralyzed Veterans of America; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; and Mr. Paul Egan, Legislative Director of the Vietnam Veterans of America.

I welcome you to the panel and will allow you now to either submit your statements to the record and summarize, if you would, in the presence of time. You can use that however you would like, at your own discretion. But at this time I will turn it over to Mr. Cullinan for his testimony.

STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. **Cullinan**. Thank you, Mr. Chairman. I will excerpt from my statement.

To begin, I wish to extend the appreciation of the 2.1 million members of the Veterans of Foreign Wars for having invited our participation in today's important legislative hearing. The Department of Veterans Affairs medical care program is this Nation' largest integrated health care system and provides an invaluable service to many of this Nation's deserving veterans. Indeed, if it were not for the VA medical care program, many veterans would have little, if any, access to health care. Thus, we are both pleased and honored to take part in today's forum, directed toward improving the health care provided to veterans by VA.

Under discussion today is draft legislation to codify and expand a number of medical programs under the VA. But, Mr. Chairman, due to time constraints, we will not attempt to address the particulars of the legislative proposals under discussion here.

Generally, the VFW is supportive of these initiatives to improve veterans health care and does not object to any of them. We view them as being carefully considered and should, indeed, benefit those veterans to whom they are directed. The VFW is thankful to you, Mr. Chairman, and the other members of the subcommittee, for your work in this regard.

At this juncture I would also express the VFW's support of your provision that certain proposed new pilot programs for veterans in the areas of medical research, PTSD, substance abuse, and homeless and chronically mentally ill be contingent upon sufficient appropriations support.

While the VFW supports the implementation of these programs, we would point out that the VA is now extremely hard pressed to fulfill its mandate under current law and that imposing additional requirements without supplying the appropriations dollars to carry them out would constitute a disservice to all veterans.

As much as the VFW supports the proposed programs, we believe VA's meager funding is already overdiluted and that to require additional expenditures would bring them to the point where they could not serve any veterans. Thus, we strongly support the provision that appropriations dollars be supplied to VA to carry out these proposed programs.

We point out, too, that the pay-as-you-go provisions of the budget accord is, in effect, already in existence at VA. If you don't supply any additional dollars and you require VA to carry out an additional program, that means the money has to come from somebody else or somewhere else. VA has been cut to the bone and can't take any more cuts, and we therefore support that particular provision requiring appropriations support.

Thank you, sir.

[The prepared statement of Mr. Cullinan appears at p. 82.]

Mr. PETERSON. Thank you. I appreciate your comments.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. I believe our written testimony covers virtually all of the issues that the subcommittee is considering in the draft legislation. I would like to take the remainder of my time to simply highlight some of the ones that are of most importance to the DAV.

Mr. Chairman, we fully support the proposal to amend section 603, authorizing fee-basis or contract hospitalization to be provided for any disability of a veteran who has a service-connected disability total and permanent in nature.

Favorable consideration and ultimate enactment of this provision will correct an unanticipated and, we believe, unintended but nevertheless prevailing requirement of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, which we view as totally restrictive in nature concerning the manner in which 100 percent totally disabled service-connected veterans are permitted to receive non-VA health care services at VA expense.

The DAV also supports the proposal that would require that reports issued by the VA's Advisory Committee on Geriatrics and Gerontology be submitted simultaneously to the Secretary and to the appropriate congressional committees.

Mr. Chairman, in January of 1990, Secretary Derwinski established and appointed the Department of Veterans Affairs Advisory Committee for Health Research Policy. The draft proposal establishing a pilot program of medical research for the purpose of improving the provision of VA clinical care clearly and precisely meets the intent of the Advisory Committee's recommendations and, therefore, has the full support of the DAV.

Mr. Chairman, we wanted to talk a little bit about your recognition of the fact that VA's Home Improvements and Structural Alterations grants, the HISA grants, have not been increased for over the last 15 years. While we fully support the proposed increase, we would urge that the subcommittee consider increasing the maximum limitation to $5,000 for service-connected disabled veterans, as recommended by the independent budget.

Mr. Chairman, the draft legislation pertaining to the issue of post traumatic stress disorder proposes a number of very meaningful and, we believe, needed improvements in the way VA deals with this issue. As such, we support those provisions.

It was sort of disheartening to read Dr. Holsinger's testimony, where he states—and I would quote—"we must again oppose this effort to direct that specific actions be taken to provide needed benefits to veterans. Clearly, additional inpatient and outpatient programs are needed to care for those suffering from post traumatic stress disorder." Continuing to quote, "However, if additional sums are forthcoming for the care and treatment of veterans, we believe programs other than those specifically for PTSD should be able to compete for the funds."

Mr. Chairman, the provisions dealing with PTSD, as well as the provisions dealing with the pilot program of medical research and the enhancement of services for homeless veterans are all subject to the availability of appropriations for fiscal year 1992. Certainly the DAV is aware of and vitally concerned with the current budgetary climate. The DAV has been dollar conscious and, I believe, fiscally responsible in our pursuit of a meaningful legislative agenda over the years, and that is no different today.

In that very regard, Mr. Chairman, the independent budget has addressed the budget deficit head on. As a result, we have outlined what we believe to be very reasonable and attainable goals and methods that formulate an alternative deficit reduction plan with the potential of exceeding the assigned reconciliation targets as contained in the Omnibus Budget Reconciliation Act of 1990.

Mr. Chairman, I mention the above only for the purpose of recognizing that the DAV is painfully aware of the pay-as-you-go provisions that we all must be considerate of in discussing legislative proposals and program enhancements. However, there are certain entitlements, issues and areas of health care that are so intrinsically linked to the direct performance of military service that they should constitute a priority area of treatment for the VA. Clearly, PTSD is one such area.

We believe and we strongly support a much needed, meaningful expansion of the program based solely on the documented need of veterans. Consequently, Mr. Chairman, we believe that there must be a firm recognition and commitment to the philosophy that certain types of care constitute a priority and should not be made available to veterans subject only to the availability of additional appropriations before such care is provided.

Mr. Chairman, that concludes my remarks. I would be glad to answer any questions you may have.

[The prepared statement of Mr. Gorman appears at p. 91.]

Mr. Peterson. If I may, I will delay questions until all of the testimony has been heard. But I appreciate your instructive comments on this.

We will now move on to Mr. Buxton.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Buxton. Good morning, Mr. Chairman, and members of the subcommittee.

The American Legion thanks you for this opportunity to share its views on draft legislation affecting various veterans health services. We respectfully request the prerogative to comment further on this draft legislation when the Veterans Health Care and Research Amendments Act of 1991 is introduced.

We have submitted a more comprehensive statement for inclusion in the record, Mr. Chairman.

Mr. Peterson. It will be included.

Mr. Buxton. The American Legion believes that certain treatment programs within the VA should be expanded and supports the establishment of new medical initiatives to meet identified needs of the veteran population. We also believe that the root underfunding of VA programs must be corrected to ensure that appropriate health care is available to all VA beneficiaries, not only those requiring specialized care modalities.

Mr. Chairman, The American Legion supports the proposal to provide outpatient dental treatment, when medically necessary, to prepare a patient for hospital admission or for a veteran already receiving VA care or medical services. We also support the increase of the eligibility threshold from $500 to $1,000 above which fee-basis dental treatment would be subjected to a second opinion, since the cost of fee-basis dental treatment may escalate and differ geographically.

The proposed authorization of fee-basis treatment or contract hospitalization for any disability or illness of a veteran who has been determined to have a total permanent disability which is service-connected is also supported by The American Legion.

Mr. Chairman, The American Legion also agrees that care for eligible veterans should be continued at the Veterans Memorial Medical Center in the Republic of the Philippines.

In regard to the increase of the limit on home improvements and structural alterations grants to $3,300 and $1,200 respectively for certain disabled veterans, this legislation is strongly supported by The American Legion and we would support amending section 617, title 38, U.S. Code.

Mr. Chairman, The American Legion endorses the recommendation of the VA Advisory Committee for Health Research Policy which provided for new research initiatives on mental illness, substance abuse, through the establishment of mental illness research education and clinical care centers, or MIRECCs, fashioned after the successful GRECC models. We agree on expansion of the research to include cardiovascular, neurological, psychiatric and geriatric, psychosocial and physical rehabilitation.

Mr. Chairman, we agree with the amendment of section 4209, title 38, U.S.C., which would expand the VA's authority to provide child care services, where deemed appropriate. Child care centers are a viable tool in the recruitment and retention of quality health care personnel.

The American Legion also believes that the reduction of the threshold of what constitutes a major facility lease would place severe restrictions upon the VA's ability to negotiate satisfactory leases, as well as potentially extending the lease process and reducing the timeliness of lease procurement. We therefore see no major improvement to VA services or operations through enactment of the proposal and cannot support that section of the legislation.

Mr. Chairman, many veterans suffering from post traumatic stress disorder are provided with specialized treatment in one of 20 inpatient PTSD units located throughout the VA system, while others are treated on general psychiatry wards, or as outpatients at mental health clinics, or by specialized PTSD clinical teams. We know of no empirical evidence regarding which treatment site is most effective. We do know, however, that many inpatient programs maintain waiting lists for admission. The VA's special PTSD Advisory Committee has recommended the expansion of both inpatient and outpatient programs. We support the draft legislation to accomplish this objective, as well as expansion of research initiatives and comprehensive strategic planning.

However, cautiousness must be applied in restricting these programs by spelling out numbers and types of PTSD services to be instituted, need and resource availability should drive this measure.

In addition, Mr. Chairman, the American Legion strongly supports the expansion of the VA's program to care for the homeless, chronically mentally ill veteran. The VA has established 45 HCMI programs in 26 States and the District of Columbia, as well as 20 companion domiciliary care for homeless veterans, DCHV programs. The American Legion strongly supports the proposal to expand this program, as well as the creation of cooperative programs such as the Department of Pennsylvania American Legion Pittsburgh-Highland Drive VAMC program, which is deemed to be highly successful.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Buxton appears at p. 97.]

Mr. PETERSON. Thank you very much. It will be entered in the record.

Mr. Egan, please.

STATEMENT OF PAUL S. EGAN, LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA, INC.

Mr. EGAN. Thank you, Mr. Chairman.

Since we are testifying on a draft bill today, I think it's appropriate to preface my summary with a couple of principles, as I have done in our written testimony as well, with the hope that each of these be borne in mind as the finishing touches are put on the final legislation that is ultimately cleared by the subcommittee and later the full committee.

The first of those principles is that we would caution against adding new authorities that would exacerbate a situation in which VA health care is authorized to do more than it is capable of doing. There are already too few dollars chasing too many authorities within the VA health care system, and it's not always the case that those new authorities that are added incrementally over the years necessarily address the needs of service-disabled veterans.

The second principle is that there is no other more fundamental, more basic, more critical role in VA health care than that of taking care of the service disabled veteran first and foremost on a priority basis. We believe, as we have said time and again in the past, that VA health care today is, in many, many facilities, substandard, and that it is inconvenient for veterans who are disabled who are dependent upon the system. We believe, therefore, that the service disabled ought to be given an opportunity to chose between using the VA for health care or using the private sector at VA expense.

On the topic of the quality of health care at VA facilities, the North Chicago revelations of late are just one more in a continuing series of examples that demonstrate to us that the problem is systemic and not isolated to one or two facilities around the country.

With those principles in mind, Mr. Chairman, we would offer comment on a couple of the provisions. First of all, I think the dental care provisions rightly authorize dental care for veterans if it's needed in preparation for hospitalization or if it's needed for those who are already hospitalized. It's hard to imagine that the VA needs that additional authority. Perhaps they do. It remains to be seen whether that authority, if it's ultimately approved, will be exercised.

Also in the dental care area, the draft bill would increase the threshold for a second opinion from $500 to $1,000, the cost in the private sector for some dental procedures. Second opinions can be used for a variety of purposes. In this instance, it's being used to assure that the VA isn't spending more of its scarce resources than ought to be spent, and that's appropriate. But perhaps it would be well to authorize veterans, particularly service disabled veterans, who are dependent upon the VA to secure a second opinion to counter what might be considered by those veterans as inappropriate recommendations for care by the VA itself.

Consistent with our principles, the draft bill already contains a fee-basis provision for service-disabling conditions that are total in nature. Why stop there? If fee-basis care is good enough for the service disabled who are totally disabled, why not for other service-disabled individuals as well?

The recruitment and retention provisions of the draft bill, there are three of those, and the first two we fully subscribe to, with the idea of a 2-year obligation under the scholarship program and the promotional items of nominal value. A third one, the credentialing of social workers, is a bit more problematic. We have no quarrel with credentialing health practitioners, no matter what the discipline, whether it's allied health or others. But over the years, the credentialling of health professionals in the various disciplines has in some respects created an artificial shortage of health care personnel.

I would recommend that the subcommittee look very carefully at the material we have added to our testimony outlining a program currently operating at a Baltimore hospital within the University of Maryland Medical System. The hiring program in the Department of Respiratory Therapy—and they, like many other hospitals around the country, were spending a lot of money contracting with temporary agencies that provide various medical specialties—what they have done is recruited recently-separated veterans with training in the military who are suitable for providing that kind of treatment. They are hired on the condition that they pursue a credential using the hospital's regular tuition reimbursement program.

It's a model that ought to lend itself not only to respiratory therapy but to all of the other health disciplines as well. It certainly would benefit the veterans. The experience at the University of Maryland hospital is that there has been a complete cessation of expenditures for contract personnel, turnover is negligible, morale is good, and the quality of care has improved ten-fold.

I see that my time has expired, Mr. Chairman, so I will close by saying, with regard to the PTSD provisions, they are inadequate. We believe strongly that those provisions currently in the draft should be adjusted to reflect the provisions of the Jontz/Evans/Ridge PTSD bill, H.R. 841. We feel so strongly about this that, where cost is concerned, this problem is so significant, is so well understood, both inside and outside of the VA, that even if the VA is required to comply with the provisions of the Jontz/Evans/Ridge bill, even if they are required to utilize existing resources without any added appropriations, that that should be done. This is clearly a service-disabling problem, whether adjudicated as such or not.

With my time having expired, I will conclude my statement.

[The prepared statement of Mr. Egan w/attachment appears at p. 101.]

Mr. **Peterson**. I appreciate your comments as well. Obviously, the PTSD problem is certainly more attached to the Vietnam veterans' circumstance than perhaps for prior veterans. That will be taken into serious consideration.

Mr. Dupree.

STATEMENT OF CLIFTON DUPREE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. **Dupree**. Yes, sir. We have already submitted our statement for the record, so I will make mine as brief as possible.

Mr. Chairman and members of the subcommittee, on behalf of the Paralyzed Veterans of America, I wish to thank you for inviting us to testify today. We are grateful for the opportunity to express our views on the various provisions set forth in your legislation, the Veterans Health Care and Research Amendments Act of 1991.

These provisions address several critically important areas within VA's health care programs: research and clinical care, PTSD and homeless programs, home improvement and structural alteration grants, and cost sharing for the procurement of medical equipment, among others. The members of the PVA have a keen interest in the VA's ability to deliver these programs in a cost-effective and high-quality manner. Directly or indirectly, such issues as cost sharing and VA's congressional reporting mechanisms, child care and improved working conditions at VA facilities all ultimately affect VA's ability to provide quality "hands on" patient care. We look forward to the eventual improvement of all the programs addressed in your legislation.

PVA is extremely grateful for the inclusion of the provision having to do with VA's Home Improvements and Structural Alterations grant program. As you know, increasing the HISA grants for our members and other eligibile veterans has been a top priority for the PVA for several years

As you know, VA is authorized to provide a one-time grant to help pay for necessary alterations to the homes of certain seriously-disabled veterans to assure continuation of treatment for the veteran's disability, or to provide access to the home, or to essential lavatory and sanitary facilities.

While the costs associated with home modifications have more than doubled over the past 14 years, the limitations on HISA grant amounts have not been increased since 1976. We appreciate your recommendation to increase the HISA grant from $2,500 to $3,300 for service-connected veterans, and $600 to $1,200 for nonservice-connected veterans. We continue to believe that the enactment of a cost ceiling of $5,000 for service-connected veterans—in addition to the $1,200 limit for nonservice-connected veterans—would provide a more equitable level of real assistance equivalent to that provided by Public Law 94-581.

As you know, the HISA provisions setting $5,000 and $1,200 limits has been introduced in S. 127, introduced this session, and has been strongly recommended by the authors of the fiscal year 1992 independent budget, as well as many other organizations which endorsed this document.

Certainly, PVA understands the restraints imposed by reconciliation provisions on new legislative initiatives. In view of the very low cost of the HISA grant provision, the strong VSO support for such improvements, and the significant benefit such an initiative would provide for seriously disabled veterans, we firmly believe this important legislation can be equitably enacted within the framework of the Budget Reconciliation Act. We will work with you in any way we can to ensure that this is done.

This is all I have to say, sir.

[The prepared statement of Mr. Dupree appears at p. 114.]

Mr. PETERSON. Thank you very much, Mr. Dupree.

All of the testimony has been very helpful and certainly will be used by the committee to perfect the legislation that is going to go forward into final form. I think, clearly, the heart of the VA programs are the medical programs. What is being done with those dollars and how to perfect the efficiencies we have to make within the VA to get that service to our people is probably best illustrated by your comments here today. I think the service organizations do a marvelous job in that. Obviously, it's clear through your testimony today that you've done a lot of homework in the process of looking through this draft. I personally appreciate that, as I am a recipient as well as a developer of legislation these days, and I keep my eye on that very closely. So I commend you for your comments and we will work with you as we develop this legislation to its final form.

But as a matter of questions, I would like to ask each of you to comment on how you reconcile the VA's testimony on the amount of home improvement benefits, as is supposedly sufficient in their view, as opposed to what some of you have said in your own testimony today? Can you give me some examples of specific problems posed by the current dollar limits that we're talking about?

I think Mr. Gorman made the first comment about raising it to $5,000, if I'm not mistaken.

Mr. **Gorman**. I think, Mr. Chairman, the figure of $5,000, that we support as an independent budget group anyway, three of which participants are here, is based simply on the fact that the inflationary factor over the last 15 years clearly has, in our view, at least doubled at a minimum the cost and the benefit that should go with that grant. I think the cost of simple construction is more than enough to account for that inflationary factor.

I believe PVA may have some specific examples but I don't want to put words in their mouth.

Mr. **Dupree**. We've got examples.

Mr. **Gorman**. Perhaps I should defer to them.

Mr. **Dupree**. Yes, sir. In our testimony we give some examples of why the HISA needs to be $5,000 in lieu of what has been introduced. The purchase of a stairway lift—living in Washington, DC, accessible housing is very, very limited. Living here, if you had to have a straight lift for a stairway, in 1976 it cost $1,570 for that lift; in 1990, it's $3,860. And if you need a curved lift, it would cost you in excess of $7,000. So if you lived in a two-story house and you really didn't have a choice, and the bedrooms are upstairs, a lift would be important. Carpenters' fees have increased by at least double since 1976.

I mean, we're talking 15 years. I've been disabled 16 years, so the thing was effective a year after I was disabled. Things don't change immediately. We need it. There's a lot of reasons why we need it.

You know, when you're talking about millions of dollars, $5,000 is not very much. It only costs you a million dollars in outlays and a million dollars in budget authority to do it.

Mr. **Gorman**. If I could add one more comment, Mr. Chairman, I think, too, in utilizing this benefit, that veterans are being told up front the basic limitation of the grant for service-connected veterans is $2,500. Therefore, if an argument were to be made that the average cost of a HISA grant not exceed that amount, I think there's a good explanation of why that is. Simply being that's what the grant is, that's what veterans are told up front and they don't as a rule exceed that amount when submitting a claim to VA. I think that is an argument that is a fairly feeble one.

Mr. **Peterson**. Okay. I appreciate your comments.

Mr. Egan, one of the things you brought up that I thought was very interesting is the suggestion on the recruitment of personnel, asking the VA to review and comment on that concept. Have you talked to any other agencies prior to this testimony?

Mr. **Egan**. You're talking about the program that's operating in Baltimore?

Mr. **Peterson**. Right.

Mr. **Egan**. I have discussed this with the Department of Labor. I have not discussed it with the Department of Veterans Affairs, although, even without having done so, it is something that they well should review. It is my understanding, for example, that at the DC VA Medical Center they are spending a large amount of money for contract temporary personnel in just the respiratory therapy area alone. It's money that could be saved if the experience in Baltimore were repeated within the VA.

Now, obviously, the Federal Government is different from the private sector in its ability to respond to the need to compete with the private sector, and it is limited by the authorities given it in terms of the benefits that can be offered. We have a professional scholarship program within the VA and it may be that some of the allied health programs are not covered under it; perhaps they should be. But it seems to me that it's a model program that is easily adaptable, not only to other hospital environments in the private sector but to other employment areas even apart from health care, and certainly should be adaptable. If not already adaptable, it should be made adaptable to the VA.

There are significant savings and improvements in health quality that can be enhanced by utilizing this kind of a program, not to mention the benefits to the veterans that are employed under it and who are, therefore, given career opportunities that would otherwise be withheld from them in the absence of already possessing some kind of credential in some allied health field.

Mr. **Peterson**. We will pursue that. I think that has potential merit.

Mr. Buxton, do you have any recommendations on ways to improve the provisions on construction funding, or should the subcommittee drop this provision, in your view, now?

Mr. **Buxton**. Are you referring to the HISA grants, sir?

Mr. **Peterson**. In the major construction area.

Mr. **Buxton**. I don't personally have anything to offer in regard to major construction, except that it appears to us that if you change the threshold of what constitutes a major lease, as far as medical facilities are concerned, there is a point in time where it jumps over and becomes a very convoluted process as a major medical care facility lease. Changing those numbers, if that's what you're referring to, appears to complicate the system and would make the lease negotiations longer and more difficult.

I don't have any specific examples for you in that area.

Mr. **Peterson**. Lastly, Mr. Gorman, you raised some good questions in your formal statement regarding the need for safeguards under a joint procurement. Would you be willing to provide the committee staff with specific recommendations to tighten that provision?

Mr. **Gorman**. Certainly. I would be more than happy to sit down and discuss that with staff.

Mr. **Peterson**. I have no other questions. Barring that, we would conclude this hearing.

We would ask if we might also submit questions to you for the record based on this testimony, as it's reviewed, if that would be permissible with all of you. I assume it would.

I would tell you that though the quality of the chair has been reduced, since you haven't had Mr. Montgomery here, rest assured your testimony will be given full weight and merit, and I do appreciate very much the opportunity to have listened to your comments today. It was very constructive in my view. We stand with you to certainly finding some solutions to some very monstrous problems within the medical care facilities that we're dealing with.

Again, thank you very much.

[Whereupon, at 11:15 am., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF HON. G. V. (SONNY) MONTGOMERY

CHAIRMAN

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

APRIL 10, 1991

THE SUBCOMMITTEE WILL COME TO ORDER.

THIS MORNING WE ARE TAKING UP DRAFT LEGISLATION COVERING A RANGE OF VA MEDICAL PROGRAMS. MANY OF THE PROVISIONS CONTAINED IN THE DRAFT BILL WERE PASSED BY THE HOUSE DURING THE 101ST CONGRESS AS PART OF H. R. 5740.

THE INTENT OF THE DRAFT LEGISLATION IS TO IMPROVE THE DELIVERY OF HEALTH CARE AND

SERVICES TO VETERANS. FIRST, IT WOULD INCREASE THE VA'S ABILITY TO RECRUIT AND RETAIN NEEDED MEDICAL PROFESSIONALS BY ENHANCING THE VA RESEARCH PROGRAM. AS STATED BY MANY WITNESSES AT PRIOR HEARINGS, THE OPPORTUNITY TO CONDUCT RESEARCH IS WHAT ATTRACTS MANY TOP CLINICIANS TO THE VA. IT WOULD ALSO EXPAND VA'S AUTHORITY TO ESTABLISH CHILD CARE PROGRAMS.

THE DRAFT BILL ALSO BREAKS NEW GROUND IN PROPOSING LEGISLATION TO ESTABLISH A "SHARED PROCUREMENT" PROGRAM. THAT PROGRAM WOULD PERMIT VA TO JOINTLY OWN AND

USE COSTLY MEDICAL EQUIPMENT WITH COMMUNITY FACILITIES. THIS PROGRAM WOULD ALLOW THE VA TO ADDRESS SOME OF ITS EQUIPMENT NEEDS. IT WOULD ALSO HELP STRETCH VA RESOURCES FURTHER BY REQUIRING HALF THE FUNDING FOR THIS EQUIPMENT TO COME FROM OUTSIDE SOURCES.

IN DEVELOPING THIS DRAFT LEGISLATION, WE HAVE BEEN MINDFUL OF THE PAY-AS-YOU-GO REQUIREMENTS OF THE LAW. WE'VE DEVELOPED PROPOSALS THAT PROVIDE NEEDED EXPANSIONS IN BENEFITS FOR OUR VETERANS. THEIR COST WOULD BE OFFSET BY MODEST SAVINGS IN ADMINISTRATION OF VA'S DENTAL PROGRAM.

Our proposal also emphasizes two important areas we highlighted in our Report to the Budget Committee. These are treatment of PTSD and care for homeless veterans. I want to commend Mr. Ridge for his concern with the need for expanding PTSD programs and Mr. Kennedy for his proposals for the homeless. I support the need for these programs. However, I think we all agree that expansion of programs should not come at the expense of ongoing medical care needs. As we advised the Budget Committee, we want to see new dollars for VA health care -- for needed new

EQUIPMENT, FOR MORE STAFFING TO IMPROVE QUALITY, FOR STATE OF THE ART TECHNOLOGY YOU'LL SEE IN A MINUTE. I WANT TO ASK YOU ALL TO WORK WITH ME TO PUSH FOR INCREASED FUNDING FOR FISCAL YEAR 1992 SO THAT WE CAN IMPROVE PATIENT CARE AND ALSO EXPAND PTSD AND HOMELESS PROGRAMS.

BEFORE WE RECEIVE TESTIMONY ON THIS DRAFT LEGISLATION, I WANT THE MEMBERS OF THIS SUBCOMMITTEE TO SEE A DEMONSTRATION OF PIONEERING WORK VA IS DOING HERE AT OUR WASHINGTON VA HOSPITAL. IT COMBINES ADVANCES IN COMPUTER TECHNOLOGY AND PROGRAMMING. IT ALLOWS DOCTORS THROUGHOUT

A HOSPITAL, OR WHEREVER THEY'RE LOCATED, TO SEE X-RAYS, ENLARGED SLIDES, OR OTHER DIAGNOSTIC IMAGES ON COLOR MONITORS LINKED TO A COMPUTER SYSTEM. I THINK THIS HAS GREAT POTENTIAL BOTH IN OUR MAJOR MEDICAL CENTERS AND IN RURAL HOSPITALS WHICH CAN USE THIS TECHNOLOGY TO GET X-RAYS INTERPRETED BY EXPERTS IN FAR-OFF METROPOLITAN CENTERS. THE COMMITTEE'S BUDGET RECOMMENDATIONS FOR FISCAL YEAR 1992 INCLUDED $62 MILLION FOR COMPUTER SOFTWARE EXTENSIONS SUCH AS YOU ARE ABOUT TO SEE. AS WE HEAR TESTIMONY THIS MORNING ABOUT LEGISLATION TO PROCURE MEDICAL

EQUIPMENT AND TO EXPAND VA'S RESEARCH PROGRAM, I THINK THIS DEMONSTRATION WILL GIVE US A FRAMEWORK TO APPRECIATE THE NEED FOR OUR LAWS TO KEEP PACE WITH VA DEVELOPMENTS.

BEFORE PROCEEDING WITH THE HEARING, I WOULD LIKE TO RECOGNIZE THE RANKING MINORITY MEMBER OF THE SUBCOMMITTEE AND MY GOOD FRIEND, JOHN PAUL HAMMERSCHMIDT, FOR ANY REMARKS HE MAY WISH TO MAKE.

STATEMENT OF THE HONORABLE TOM RIDGE
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
REGARDING DRAFT HEALTH CARE LEGISLATION

APRIL 10, 1991

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to submit a written statement regarding the proposed legislation being considered this morning. This morning's hearing coincides with the funeral of our dear friend and respected colleague, Senator John Heinz. He will be sadly missed by all Pennsylvanians, including our veterans, and many of us here in Washington, D.C. We have lost one of our finest leaders in Congress and the American people have lost a true public servant.

Mr. Chairman, this morning's hearing focuses on proposed legislation to address a number of areas of concern, including dental care, child care, medical research, the procurement of medical equipment, the treatment and care for post-traumatic stress disorder (PTSD) and the expansion of the VA's homeless chronically mentally ill program. The majority of these provisions address very real needs of the Department of Veterans' Affairs that have been considered in the past but encountered various roadblocks in the legislative process.

In the current budget climate, our primary concern must be to provide care and services to those that are most deserving. One group of veterans that falls into this category are those afflicted with

PTSD. This Subcommittee is well aware of the number of veterans suffering with this disorder, as well as the small percentage actually receiving care in our VA system. These statistics cannot be overlooked, particularly in light of the number of men and women returning from the Persian Gulf conflict that will suffer from PTSD. Dr. Detre, from the University of Pittsburgh Medical Center, has attested first-hand to his knowledge of the suffering experienced by those returning from the Persian Gulf. I certainly appreciate his insights offered at today's hearing.

I was extremely pleased with the inclusion of $4 million in the Dire Emergency Supplemental bill for the establishment of 8 inpatient units to treat those with PTSD. This is an essential step in the direction of providing care and eliminating the waiting lines that persist in many areas of the country.

Mr. Chairman, I am pleased that the Committee, in its own recommendations to the Budget Committee, determined that increased funding should be provided for this disorder. Concurrent with the recommendations of the VA's own advisory board, the Special Committee on PTSD, and the Independent Budget's recommendation, these recommendations attest to the need for and support from the Committee, various veterans organization, and VA personnel as to the need for additional resources for PTSD.

The provisions expanding inpatient units, clinical teams, and dual diagnosis centers within the VA are clearly warranted and are in line with the recommendations made to the Budget Committee by the House

Veterans' Affairs Committee. Unfortunately, these provisions may become moot due to language which makes them conditional on a certain level of appropriations beyond what the President recommended in his 1992 budget proposal. Just yesterday, the Budget Committee reported out its budget resolution. It does not meet the appropriations' levels to fund the PTSD, homelessness and medical research pilot program provisions as established in the legislation. In other words, these provisions may not even have a chance to get out of the starting block because of the "subject to the availability of appropriations" language. Mr. Chairman, I hope that you will reconsider this language prior to consideration by the full Committee to ensure that a window of opportunity exists for these provisions.

This Subcommittee and the full Committee are faced with many difficult decisions regarding spending priorities and the best manner of delivering care to those truly deserving in the current budget climate. I trust that my colleagues share my opinion that $7.4 million for PTSD treatment and care is not too much to ask for one of the most compelling problems facing veterans of past conflicts and those of more recent conflicts.

Mr. Chairman, again let me thank you for the opportunity to submit this statement. I look forward to reviewing the testimony submitted as part of today's hearing and to working with you to see that a reasonable and fair approach can be incorporated into this legislation prior to the full Committee's consideration.

JOSEPH P. KENNEDY II
8TH DISTRICT, MASSACHUSETTS

COMMITTEE ON BANKING,
FINANCE AND URBAN AFFAIRS

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FINANCIAL INSTITUTIONS SUPERVISION,
REGULATION AND INSURANCE
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COMMITTEE ON VETERANS' AFFAIRS

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CONGRESSMAN JOSEPH P. KENNEDY II
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
"DRAFT HEALTH CARE IMPROVEMENTS"
APRIL 10, 1991

Mr. Chairman, as you are aware that during the past year on this committee, I have focused a great deal of my work on the issue of homeless veterans. Over 40% of the adult male homeless population are veterans or between 70,000-200,000 of the homeless population are estimated to be veterans. The DVA has a very fine program reaching out to help homeless veterans but the outreach workers' caseloads are burgeoning and they need some desperate relief.

I am extremely grateful for the Chairman recommending in the Committee's budget request a $3.55 million increase above the President's request for homeless veterans programs for FY '92. This modest increase will enable the Department of Veterans Affairs to expand their existing outreach efforts and also allow for a $300,000 public/private partnership program to establish a model homeless program in one city. The increase provided for extra staff at existing programs and for the expansion of the program into 4 additional sites. The Presidents FY '92 budget for homeless veterans provided just an inflationary increase and the

FY '91 budget straight lined the program.

I was very disappointed to learn that when the Committee drafted authorizing language for this program, they inserted language that basically is a "kiss of death" for this worthy program and as I understand, for another important program that could help homeless veterans, and that is, the PTSD program. The language reads that if appropriations for the medical care account and medical administration account do not exceed the President's budget request by $225 million and $7.5 million respectively, then these programs are not to be funded for this year. I just learned that the Budget Committee marked-up a budget yesterday that did not meet this criteria. Historically, the Appropriations Committee has come under the Budget Committee marks.

The solutions to the problems of homeless veterans are within our reach. These men and women who dutifully served our country when we needed them the most now need our help to get them through this difficult time of their lives. I hope the Chairman will work with me to see that these important programs are not doomed for this year.

Opening Statement of Christopher H. Smith

Veterans Subcommittee on Hospitals and Health Care

April 10, 1991

Mr. Chairman, I am pleased that the Subcommittee is holding this hearing today to examine the need for changes in veterans health care services.

Today's hearing will focus on proposed legislation which is designed to increase the ability of the Department of Veterans Affairs to offer improved services to the men and women who have served in the defense of our nation. The draft legislation would bring several veterans' benefits back into line with the current economic conditions. In recent years, inflation has eroded the level of benefits accorded to our nation's veterans, a situation that we must continue to correct.

Mr. Chairman, last year, I authored legislation which increased the level of educational support for students who agreed to serve in VA health care facilities. In the draft legislation that we are considering today is a provision which would extend the requirement for service in veterans facilities from one year to two years for recipients of the health care professional scholarships.

The draft legislation under consider today also addresses the need to improve child care services at veterans facilities. In order to maintain a sufficient level of staffing at VA facilities we must provide a commensurate level of benefits accorded those working in the private sector.

Finally, Mr. Chairman, the draft legislation proposes expanding programs assisting homeless veterans and veterans suffering from post traumatic stress disorder. In addition, several of the provisions contained in the draft legislation we are considering today were previously approved by the Committee last year and several have been strongly recommended by the Department. I hope that we can move quickly to their approval.

Mr. Chairman, we have an obligation as a nation to provide prompt, efficient and comprehensive health care to our nation's veterans. I want to thank you, and the Ranking Minority Member, Mr. Hammerschmidt, for your very timely consideration of proposals to improve the delivery of health care to the men and women who have served our nation with honor and distinction.

STATEMENT OF
JAMES W. HOLSINGER, JR., M.D.
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
APRIL 10, 1991

Mr. Chairman and Members of the Committee:

I am pleased to be here to provide our views on various legislative proposals aimed at improving the VA health care system and enhancing our ability to effectively administer that system. I am particularly pleased to comment on several proposals which appear to be the same as VA legislative proposals introduced in the last session of Congress, but which were not acted on. I preface my comments by stating that they are based upon brief summaries of the proposals prepared by your staff, and not upon the actual language of any bill.

Child Care

Mr. Chairman, the provision of child care services in the work place has long been recognized as an excellent tool for recruiting and retaining employees. But more importantly, it is needed for the well-being of our employees who are working parents. Child care centers exist in some of our medical centers, but in many other locations the resources (both human and financial) are not there to create centers under existing legal authority. Your new proposal would provide an additional tool to enable us to meet the need for child care services.

As you know, limited authority now exists for the Canteen Service to establish and operate child care centers. Your measure would alter that authority to permit us to provide for the operation of child care centers either directly (VA would hire caregivers, for example) or through service contracts. Priority for services would be given to VA employees, followed by other Federal employees, employees of affiliated schools, and the general public. VA would establish charges for child care, with preferential rates for VA employees, which would be sufficient to meet all staffing costs. The measure would allow us to establish centers in surplus space, and if that is not available, to obtain space through construction or leasing. We could also provide for other services and amenities such as utilities and furnishings.

This proposal would meet a need in the VA, and we support it. However, we also recommend that you provide us with another alternative for developing child care centers by passing the so-called "enhanced use" legislation. That legislation, submitted by the Administration last year, would allow us to enter into competitive long-term agreements with private sector entities to permit those entities to construct and operate facilities such as child care centers on VA property. In those locations which have open space available for construction of facilities, "enhanced use" agreements may be the most cost-effective method for us to obtain needed child care facilities. In short, we would like to have both your provision and the enhanced use alternative.

DENTAL BENEFITS

Another proposal would make two changes in our authority to provide dental benefits on an outpatient basis. We support both proposals which are identical to measures we submitted to the Congress last year, and which are again in our legislative program for Fiscal Year 1992. The first proposal would authorize outpatient dental care to veterans when necessary to prepare them for a hospital admission, or for a veteran otherwise receiving VA care. Such dental work is often necessary to, for example, prepare a veteran for surgery, or other procedures which could be compromised by dental infection. Under existing law, we can provide most outpatient treatment needed to prepare a patient for hospitalization, but not outpatient dental care. As a result, we hospitalize patients to perform needed dental work which could be performed on an outpatient basis at much less cost.

The second dental proposal in the bill would raise from $500 to $1000 the threshold at which we must obtain a second opinion before authorizing fee-basis dental care. Existing law requires a second opinion for procedures over $500, but with the rising cost of medical and dental care, that figure is too low. By raising the ceiling to $1000 we expect to avoid many costly dental reexaminations, saving much more than is saved by the second examinations.

CONTRACT HOSPITAL CARE

Your next proposal would authorize us to contract for the hospitalization of permanently and totally disabled service-connected veterans for any disorder. We currently have the authority to contract for hospital care for these veterans when it is for the service-connected condition. We do not believe this additional authority is needed at this time.

ANNUAL REPORT ON FURNISHING NONSERVICE-CONNECTED CARE

The next proposal would continue a requirement imposed in 1986 that we submit an annual report to Congress on implementation of the "means test." It would require a report for Fiscal Years 1991, and 1992. We oppose this proposal as simply unnecessary. In our view, if Congress needs specific information of the type included in this report, we would be pleased to provide it, but we object to annual reporting requirements of this type.

EXTENSION OF AUTHORITY TO PROVIDE CARE IN THE PHILIPPINES

Another proposal would extend for one year, the President's authority to enter into contracts with the Veterans Memorial Medical Center (VMMC) in the Philippines. These contracts provide payments for hospital and nursing home care to United States veterans in that hospital. We have long recognized the obligation to provide care to Filipino veterans who served in the U.S. Armed Services, and the authority to provide contract care is still needed to fulfill that obligation. Accordingly, we support an extension. To avoid having to reauthorize this program every year, however, we recommend that the extension be for a five year period.

It is noteworthy, that the bill does not extend the Secretary's authority to make grants to the VMMC for replacing and upgrading equipment and rehabilitating the hospital's physical plant and facilities. Annual grants for those purposes have been authorized for many years. We recommend that you extend the grant program for five years, and authorize $500,000 annually, as a cost-effective way for the VMMC to meet the needs of its facility, staffing, and equipment.

LICENSURE OF SOCIAL WORKERS

You next propose to statutorily establish education and licensure qualifications for newly employed VA social workers. The proposal would direct that all of our new appointees hold a

Master's Degree in social work, and it would require licensure, certification, or registration if the State where the individual practices requires that. In individual cases, we could waive the license, certification or registration requirement and allow the social worker up to three years to complete the State's requirements.

We strongly support this proposal. Currently 45 States, the District of Columbia, Puerto Rico and the Virgin Islands regulate the practice of social work through licensure, certification or registration. The Public Health Service has established licensure as a basic requirement for social workers employed by that agency. The Joint Commission on Accreditation of Hospitals, in its hospital accreditation manual, designates current licensure, registration or certification as a "key factor" in the accreditation decision process. Finally, insurance companies and other third party payers require that the care be provided by individuals with appropriate credentials. We can't have less stringent qualifications for social workers at VA than those prevailing in the health care community generally.

OBLIGATED SERVICE OF VA SCHOLARSHIP RECIPIENTS

The next provision would change the law to require a minimum two-year service obligation for participants in our Scholarship Program. We strongly support this proposal. As you know, we provide scholarships to students studying for various health-care professions. In exchange for assistance, scholarship recipients must agree to work for VA for a specified period. The service requirement was originally a minimum of two years, but that was changed to one year in 1988. Apparently, it was changed to make the scholarship program obligation consistent with the obligation in the new Tuition Reimbursement Program, which is one year.

Our principal difficultly with the one-year period of service is that with the time consumed by orientation and on-the-job training, we are actually assured of receiving only a very short period of effective service. Typically seven to eight months have elapsed before a newly graduated nurse can function independently, and before we begin to recoup the full benefit of our investment. By contrast, the two-year minimum would allow us roughly fourteen months "journeyman" service before a graduate completes his or her employment obligation. The longer period would also help stabilize staffing and reduce turnover.

PURCHASE OF PROMOTIONAL ITEMS FOR RECRUITMENT PURPOSES

Another proposal would authorize us to purchase small items of nominal value to give to potential recruits. We do not believe such a provision is necessary to meet our recruitment needs, and accordingly, we cannot support this proposal.

GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE REPORTS

The next proposal would require that when our Advisory Committee on Geriatrics and Gerontology submits a report to the Secretary, that it simultaneously submit the report to the Senate and House Veterans Affairs Committees. We oppose this proposal.

Under current law, the Advisory Committee reports are sent to the Secretary who in turn transmits a report to the Congressional committees with any comments and recommendations on the Advisory Committee's report. The Geriatrics Advisory Committee, like all such committees, was established to provide advice to the Secretary. When the Committee prepares a report, it should be for the benefit of the Secretary, and after it is reviewed, a report can be sent to the Congress. To require that the report be simultaneously submitted to the Congress would tend to undermine the Secretary's authority, and inhibit his or her ability to accept or reject findings and recommendations of the committee.

HOME IMPROVEMENT AND STRUCTURAL ALTERATIONS BENEFIT INCREASE

You propose to increase the maximum amount of the grants we make to eligible veterans for home improvements and structural alterations which are necessary for treating the veteran in the home, or for allowing the veteran access to the home or to lavatory facilities. Grants are typically used for such things as widening doors and building ramps to allow wheelchair access, or putting grab bars in a lavatory. The law now provides a maximum lifetime allowance of $600 for nonservice-connected veterans, and $2500 for service-connected veterans, and this provision would increases those amounts to $1200 and $3300 respectively. We have seen no evidence that the amount of this benefit is insufficient to meet the needs of eligible veterans, and we thus cannot support this increase.

VA EXEMPTION FROM THE CLINICAL LABORATORY IMPROVEMENT ACT

The next proposal would clarify that VA is responsible for establishing standards in its laboratories, and that the Clinical Laboratory Improvement Act (CLIA) does not apply to VA laboratory facilities.

The Clinical Laboratory Improvement Act of 1967 essentially directed that the Department of Health and Human Services (formerly HEW) regulate clinical laboratories throughout the country. The law was originally aimed at controlling the many small labs which, in "sweat shop" fashion, were processing hundreds of pap smear tests a day with little quality control. The Act, administered by the Health Care Financing Administration (HCFA), has never been applied to VA labs. However, Congress amended the Act in 1988 to extend the HCFA's jurisdiction over additional labs, and proposed HCFA regulations to implement the amendments indicate that HCFA now reads the law as applying to our VA labs. We are currently discussing this situation with the Department of Health and Human Services and a position on exempting VA from the Clinical Laboratory Improvement Act is under development.

PILOT PROGRAM FOR MEDICAL RESEARCH RELATED TO CLINICAL CARE

Your next proposal would authorize, on a pilot basis, a new medical research program focused on clinical care in the areas of mental illness, alcohol and substance abuse, and neurologic, psychiatric, and geriatric rehabilitation. The program would fund research at a medical center only after the center enters into an agreement with a medical school or other school or institution with which we are affiliated, to jointly carry out the research. The affiliated institution would be required to partially fund the research, or provide in-kind services in support of the research. The proposal also would specify that we have a peer review process to determine the most meritorious proposals.

Interestingly, this proposal, (and two other proposals I will address later in my testimony) would explicitly provide that the program would be authorized subject to Congress appropriating an additional $43 million over and above the President's budget for Fiscal Year 1992. I want to applaud your recognition that we cannot continue mandating new health care programs at the VA without acknowledging the potential costs that VA would incur in carrying out these directives.

However, despite the welcome recognition of the costs of new directives, this provision and other similar mandates in this set of proposals are not necessary and hamper our ability to effectively manage veterans' health care progrmas. Precise directives deprive managers of the flexibility needed to provide our veterans with the services and programs which best meet their wide ranging, and ever changing needs.

For these reasons, we cannot support this proposed new pilot research program. In our view, it simply isn't necessary. As a practical matter we now have the authority to do everything that this measure would require. We can now enter into sharing arrangements with affiliated institutions whereby each party can share specialized medical resources, including research. We also can establish priorities within our research program to target research toward specific needs. Indeed, our medical research program now does just that. In the President's budget for this year, we identified a number of special research initiatives in the very areas that this proposal would target.

In some respects, the measure appears to be an alternative to H.R. 111, which would authorize creation of research centers at affiliated institutions, funded by VA and DOD. In our view, this proposal is certainly more palatable than that bill, but we still see no need for the new program. If additional funds are forthcoming for VA research, we would prefer that they be allocated through the existing competitive process which is integral to our existing research program, or to those areas that we determine are most worthy of additional funding. Indeed, I believe our track record over the years has proven that we have the ability to effectively carry out research in those areas which best serve the mission of the Department.

POST-TRAUMATIC STRESS DISORDER

The next proposal would direct us, during fiscal year 1992, to establish at least five additional specialized inpatient PTSD units, ten additional PTSD clinical treatment teams, and five outpatient programs for the treatment of veterans with both PTSD and a substance abuse disability. In a similar fashion to the research program discussed above, the proposal would provide that we carry out the PTSD expansion, and a homeless program discussed later, only if Congress appropriates $225 million more than requested by the President for the medical care appropriation, and $7.4 million more for the MAMOE appropriation.

We must again oppose this effort to direct the specific actions to be taken to provide needed benefits to veterans. Clearly additional inpatient and outpatient programs are needed to care for those suffering from post-traumatic stress disorder, and we anticipate bringing new programs on line. We do object, however, to legislation directing the precise actions that we must take to meet the needs of those with PTSD.

As was the case with the proposal for a research program, we applaud your making this provision subject to the appropriation of sums in addition to those already requested by the President. However, if additional sums are forthcoming for the care and treatment of veterans, we believe programs other than those specifically for PTSD should be able to compete for the funds. I am virtually certain that in any competition for funding, the needs of those with PTSD will fare well. But we must recognize that there are also other needs. When specific programs are mandated, as would be the case with this proposal, we as managers lose all flexibility to meet other needs which may have an even higher priority than the programs we are reviewing today.

PROGRAMS FOR HOMELESS VETERANS

Your next proposal would first direct that we expand our program for homeless chronically mentally ill veterans, the HCMI Program, by augmenting staff at existing HCMI sites, and by adding new programs in four additional locations with a large unmet need for services. The measure would authorize appropriation of an additional $3.25 million for the program over and above amounts currently authorized. The proposal would also mandate that we establish a new pilot program for homeless veterans under which we would be required to perform outreach to homeless veterans through the use of vans or other transportation, provide the veterans with medical care, and provide the veterans with transitional housing. The proposal would authorize appropriation of $300,000 for the pilot program. Again, the section would require that we carry out both the HCMI expansion, and the new pilot program, only if Congress appropriates a specific sum in addition to that requested in the President's budget.

As with the two other new programs which this bill would mandate, pertaining to research and to care of those with PTSD, we cannot support this provision concerned with homeless veterans. We believe it would be more appropriate to allow us to determine, through our normal planning processes, whether additional HCMI sites are warranted, and whether available funds are best used to enlarge existing HCMI programs, or expand other health-care programs which can also be of great benefit to homeless veterans. As is the case with PTSD programs, we are virtually certain that in any prioritization of programs needing additional funding, homeless programs would fare well. But, we object to a mandate of this sort which removes our discretion to determine which programs best meet the needs of veterans in general, and homeless veterans specifically.

Also, with respect to the pilot program, we believe authority already exists to do virtually everything proposed. In fact, we are already carrying out somewhat similar programs in several places. Thus, the HCMI programs throughout the country now perform outreach on the streets with teams of health-care professionals. Those outreach teams use various means of transportation to bring veterans into the system, and if it is not already being done, they could certainly use vans. Persons brought into the HCMI programs also receive health-care benefits. Finally, as you are aware, we are now in the process of developing a so-called "independent living housing" program where the Department is purchasing residential homes in communities in which veterans live while participating in compensated work therapy programs. Homeless veterans could certainly be enrolled in compensated work therapy programs, and if it is suitable, could live in one of these therapeutic residences. The bottom line for me is that if we have the authority to undertake a program, and are for the most part actually doing it, there is no need for a statutorily mandated new pilot program.

EXTENSION OF AUTHORITY TO ESTABLISH RESEARCH CORPORATIONS

We support the next proposal which would extend for one year the authority of VA medical centers to establish independent nonprofit research corporations which serve to assist VA in funding research at the medical centers. We would, however, recommend that the authority be extended for five years rather than one year. We will propose a five year extension in draft legislation we plan to submit to the Congress.

As you know, the authority to establish research corporations was first granted in 1988. Since then, approximately fifty percent of our medical centers with research programs have established corporations. Others remain interested in setting up corporations, but have not yet been able to do so. The corporations are able to accept gifts and grants, and enter into contracts to fund VA research more easily than was formerly the case. Some of the existing corporations have been quite successful in garnering donations which are of great benefit to the research programs. We are hopeful that with an extension of the authority, many more medical centers will have the opportunity to set up these entities.

ACQUISITION AND SHARING OF ADVANCED MEDICAL TECHNOLOGY

The next proposal would clarify the authority for, and greatly enhance our program for allowing medical centers to acquire advanced medical technology jointly with other institutions in the community, and share that valuable equipment. For several years we have been acquiring highly sophisticated and expensive medical equipment in conjunction with other health-care entities, usually affiliated institutions. Acquisition costs are shared, and the resource itself is shared. However, the existing legal authority to undertake these joint ventures is somewhat convoluted, and not conducive to easily accomplishing the desired goal. This proposal, which we strongly support, would rectify those problems.

Under our existing program, VA must acquire and hold title to any equipment purchased, and then share the equipment with the other health-care entity pursuant to a sharing agreement. To assist with the initial acquisition costs, the sharing partner must make a donation to the VA which is then used for the purchase. Problems have arisen because many potential sharing partners are unwilling to pay part of the cost of equipment without being allowed to share title. Others, particularly public institutions, cannot "donate" funds to another public institution such as the VA. Some potential partners want to depreciate their portion of the equipment for which they "paid." Also, it often takes a long period of time for equipment to be delivered after an order is placed. If a sharing partner has made a donation toward that purchase, the money lies idle, without earning any interest, until the equipment is actually received.

Your measure would rectify all of these problems. It would permit VA and the sharing partner to agree to hold title jointly, encouraging more institutions to compete for participation, and allowing VA the luxury of choosing from more and potentially better proposals. It would permit us to transfer our interest in the equipment to the sharing partner if that is in our interest, and it would require the sharing partner to pay one-half the depreciated purchase price of the equipment if it wanted to obtain our interest in it. In short, the proposal would authorize a better, well thought out program for allowing us to work with our partners in the health-care community to share much of the new and exciting, but very expensive, medical equipment.

MAJOR MEDICAL FACILITY ACQUISITIONS

The next proposal, which we anticipate would be virtually the same as a section in H.R. 5740, a bill introduced in the House last year, would provide that Congress could not appropriate any funds for us to acquire a major medical facility, or a major medical facility lease or lease renewal, unless funds for the project are specifically authorized by law. A major medical facility project would be defined as a project costing in excess of $3 million, and a major medical facility lease would be defined as any lease, or lease renewal, exceeding $300,000. We understand this measure is intended to assure that scarce funds be used in the most efficient manner. We support that goal, but believe this is the wrong way to achieve it. This measure may, in fact, have the opposite result. We strongly oppose the provision.

In our view, the measure would impose new and undesirable restrictions on our ability to efficiently perform advance planning and development of major construction projects. Currently, through language in our annual appropriation act, we are permitted to use funds from the advance planning fund, and the design fund, for advance planning and design of projects even though those projects may not have been formally considered and approved by Congress. This proposed new provision would restrict the Secretary from expending funds for any major medical project unless funds were specifically authorized by law. Consequently, it would appear to override language currently in our appropriations act. Having the flexibility to perform advance planning and design of projects in advance of Congressional approval for their construction is a significant aid in our effort to meet veterans' anticipated medical care needs in a timely manner while at the same time maximizing the value obtained from limited construction funds. We would recommend preserving that flexibility by revising section 5004(a) of title 38, United States Code, to specifically recognize that expenditures from the advance planning fund and the design fund would be exceptions to the Congressional approval requirements otherwise applicable through that statute.

This proposal would also make it very difficult for us to obtain major medical facility leases, and renewals of such leases. For example, if we seek to renew a major lease, that renewal would clearly be jeopardized if it were made contingent on enactment of legislation authorizing the renewal, as this measure would require. Lessors may not be interested in waiting for the enactment of legislation before leasing property, or renewing a lease.

ACQUISITION AND USE OF REAL PROPERTY

Finally, the last proposal would remove a restriction now in the law which precludes us from acquiring and using real property, or accepting donated real property, before obtaining Department of Justice approval of the title. The Justice Department would still review and approve property acquisitions. With this new provision, however, we would be able to obtain property more quickly when necessary, and let the technical review process follow. This measure would also authorize the Secretary to acquire property in situations when fee simple title would not vest in the United States. We support this section.

Under existing law, before we can expend funds to acquire real property, or accept a donation of real property, the Attorney General must determine the sufficiency of the title. The authority to examine title has been delegated to other Federal departments and agencies in several instances, but not to the VA. We must submit all title documents to the Justice Department for approval which can slow down the acquisition process. Under this provision, we would continue to seek Justice Department approval of title, but would be permitted to expend appropriated funds to acquire and use property, or accept donations of property, pending final Justice Department approval.

The other provision of your measure would permit the Secretary to determine that a lesser than fee simple interest in property might satisfy VA's needs and be sufficient for the purposes of an impending VA project. In some instances, we may not be able to acquire a fee interest in property on which we desire to construct a facility. With this provision, the Secretary could determine that, for example, a long term lease would provide the VA with sufficient interest in the property in order to build a permanent facility. We believe this authority will enhance our ability to acquire property necessary to serve the needs of veterans.

Mr. Chairman, this completes my testimony. I would be pleased to respond to any questions.

University of Pittsburgh
HEALTH SCIENCES
Senior Vice President
UNIVERSITY OF PITTSBURGH MEDICAL CENTER
President

STATEMENT OF

THOMAS DETRE, M.D.

PRESIDENT

UNIVERSITY OF PITTSBURGH MEDICAL CENTER

SUBMITTED TO THE SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

Veterans' Health Care and Research
Amendments of 1991

April 10, 1991

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Good morning, Mr. Chairman. My name is Thomas Detre, M.D., President of the University of Pittsburgh Medical Center. The University of Pittsburgh Medical Center is an academic medical center dedicated to a three-fold mission of biomedical research, education and training, and clinical care.

I served as the Chairman of the Advisory Committee for Health Research Policy of the Department of Veterans Affairs (VA) which was appointed by Secretary Derwinski in January of 1990 to review the VA medical research program. I am here today to report to this Subcommittee the findings of that Committee in light of draft legislation, the "Veterans' Health Care and Research Amendments of 1991", and the Bush Administration's budget proposal for the VA for FY 1992.

First, I would like to thank Chairman Montgomery and the members of the House Veterans Affairs Subcommittee on Hospitals and Health Care for their dedication to addressing the needs of United States veterans through a review of the health programs available at the Department of Veterans Affairs. The rising cost of delivering health services coupled with national budget constraints make meeting the health needs of veterans an overwhelming challenge to health professionals and policy makers. I commend this subcommittee for their hard work and commitment.

In presenting the findings of the Advisory Committee, may I first explain its mission. Secretary Derwinski brought together a number of respected researchers, policy makers,and physicians who were charged with three tasks: first, evaluating the relevance of VA research to the medical and health care of veterans; second, measuring the appropriateness of the research vis-a-vis the work of other federal agencies including the National Institutes of Health (NIH); and, third, reviewing the effectiveness and significance of VA research. To accomplish its task, the Committee met with research leaders at VA hospitals, conducted site visits to VA medical centers, solicited the views of a large number of national organizations connected to VA research, and received comments from the public.

The VA medical research program, conducted at affiliated VA medical centers, was established to upgrade the care of veterans after World War II. The funding for VA research started at a low level in 1946, increased significantly during the 1950s and 1960s and stabilized between 1970 and 1985. Since 1985, as I am sure you are all aware, the funding level has somewhat decreased. The mission of the VA medical research program, however, remains unchanged. It serves two major functions: to attract, educate, and retain superbly trained, research oriented physicians at VA medical centers; and to advance the diagnosis and treatment of health problems prevalent among veteran patients. The VA medical research program continues to promote these objectives by providing funding, through a peer review process, to those research projects that are deemed meritorious by the review board.

One charge of the Advisory Committee was to assess whether VA research was appropriate to the role of the VA in providing medical and other health care services to veterans. The Committee found that, first of all, the design of the VA medical research program is such that it promotes and supports the physician investigator who, by the nature of his/her work, is clinically oriented. This approach directly involves the veteran patient in the advanced care that research often produces. In addition, the medical research of VA physicians attracts top quality researchers and technicians to join the staff of VA medical centers, ensuring high quality care for the patient. Clearly, research is an important tool for the development of advanced clinical techniques and for the superior staffing of a VA medical center.

The Secretary of Veterans Affairs also posed the question of the appropriateness of VA medical research in light of research conducted at other federal agencies including NIH. Significant biomedical research is conducted and funded by numerous federal agencies. The Committee found that what was unique to VA medical research was the strong clinical orientation as shown by the number of physicians who were granted funding for their research projects. Seventy-five percent of the available VA funding is awarded to M.D. scientists, while NIH grants 75% of its available funding to non-clinician, Ph.D. researchers. The medical research conducted at VA centers serves to complement the work being done at and through other federal agencies. As competition for NIH extramural funding increases, the VA medical research program fills a gap in the clinically oriented research that is being conducted in the United States and advances medical science to benefit all patients.

The Committee strongly supports the continued research efforts of the VA and believes the quality of this research to be extremely high. The Committee noted in its final report to Secretary Derwinski that there were several concrete factors that support this opinion including: the amount of funding received by VA investigators from sources outside the VA ($163 million in FY 1989); the fact that two VA investigators have received Nobel Prizes; the

300 landmark publications that have been produced by the VA over the past thirteen years; and the supplemental salaries received by many VA physicians for their contribution to medical centers outside the VA network. The Advisory Committee's site visits to VA medical centers confirmed its conclusion that the VA research system is of the highest quality.

There were, however, several suggestions that the Committee made in its final report that I believe should be brought to light during this hearing. The VA medical research program, in accordance with its mission to improve the quality of health care for veterans, has established excellence in certain fields that pertain to the care of veterans. For example, the primary function of the current rehabilitation research, and development program is the development of devices that can improve the quality of life of a veteran in need of prostheses, sensory aids, and mobility assistance. The VA program has become the mainstay of this type of research in the United States. and this emphasis should be continued.

There are other areas of medicine that the Advisory Committee believes should be expanded under the VA health care system so as to better serve veterans. Among the recommended research priorities are: mental illness, including neurologic and psychiatric rehabilitation; geriatric research to improve the quality of life of the increased numbers of older veterans; programs for alcohol and substance abuse and related disorders; and cardiac conditions. In addition to recommending that the VA medical research program target and prioritize certain specialties that specifically pertain to the care of the veteran, the Advisory Committee also recommends that the VA continue to improve the funding strategies it has adopted from the 1977 National Academy of Sciences review.

In noting the suggestions of the Advisory Committee to improve and prioritize the funding of projects in the VA medical research program, I believe it is equally important to comment on the Committee's concern that the funding of these new initiatives in no way undermines the current funding mechanisms in place at the Department of Veterans Affairs. A balance must be reached, within budgetary constraints, between the number of currently-funded research projects and new initiatives that the VA may undertake. This raises a question about the final mandate that Secretary Derwinski submitted to this Advisory Committee: a recommendation for the funding level of the VA medical research program for FY 1992.

The funding level for the VA medical research program has declined over the past five years as budgetary constraints have forced cutbacks. The total number of proposals submitted to the VA for merit review in 1986 was 1,140, and the number of proposals funded was 722. In 1990, this rate dropped considerably with only 542 funded projects from 1,250 submitted proposals. More astonishing, however, is the number of projects considered meritorious by a review panel yet not receiving funding due to budget constraints. The number of these projects rose from 125 in 1986 to 608 in 1990. The declining rate of meritorious projects that receive funding sharply defines one of the budgetary problems in the VA medical research program: a greater percentage of research projects deemed worthy of funding by a peer review process are going unfunded.

The Advisory Committee's funding recommendation for the VA for FY 1992 is $235 million for medical research, $28 million for rehabilitation research, and $17 million for health services research for a total of $280 million. The recommendation is significantly higher than the President's budget proposal of approximately $216.8 million for VA research for FY 1992. The lack of appropriate funding for research at the VA will undermine the excellent and productive work supported by the Department. It is essential to the continued success of the VA medical research program and veteran medical care that the funding for FY 1992 be supported at a level adequate for the needed and unique research supported by the VA.

In addition to the funding level concerns mentioned above, the Advisory Committee was distressed by the analysis of the FY 1991 VA budget request which mixes direct VA research appropriations with indirect support coming from the medical care budget. Although the Committee finds it appropriate to use indirect funding for the research projects conducted at the VA, these funds cannot substitute for direct research appropriations which allow the purchase of research equipment and provide salaries to research staff and technicians. I hope that the two areas will be kept distinct in the FY 1992 budget.

One suggestion in the draft language of the "Veterans' Health Care and Research Amendments of 1991," which would address the problem of purchasing research and clinical equipment in light of the budget constraints facing the VA, is the joint purchase of technology by the VA and a non-VA medical center so that both would benefit from the same equipment. Increases in the shared equipment program will lead to the development of stronger research ties between medical institutions and the VA and result in greater progress in the development of clinical treatments.

The current procedure, which permits joint sharing of the cost of equipment but retention of ownership by the VA, fails to take into account the significant commitment of money, personnel, and supplies required of the non-VA sharing partner, especially if the equipment will be located at the non-VA facility. According to the proposal in the "Veterans' Health Care and Research Amendments of 1991," the cost-sharing aspect would continue, but title to the medical equipment would be held jointly by the VA and the non-VA health care facility. The VA could transfer its interest to the sharing partner under certain circumstances upon payment of one half the depreciated purchase price. This transfer possibility and shared title make the role of the sharing partner more appealing to health care facilities. The VA medical centers still benefit from having the availability of state of the art equipment for which they have had to pay only half the cost and often the sharing partner subsidizes personnel, supplies, and siting costs.

The entitlement by the sharing partner to the accrued interest on the sharing partner's escrow fund is appropriate and necessary, since significant monies must be placed in escrow for a lengthy period of time. This proposal is also consistent with proper business practice.

The emphasis on the treatment of post traumatic stress disorder (PTSD) in the draft legislation, i.e. the establishment of new inpatient and outpatient units and clinical treatment teams, is another area that exemplifies the important connection between VA research and patient care. Members of the military are returning from Operation Desert Storm. The VA experience with World War II, Korean War, and Vietnam War veterans has shown the necessity for prompt, continuing, and even long term intervention if the service-based disorder is to be properly addressed. As a resident of western Pennsylvania, the base for the 14th Quartermaster Detachment which suffered so tragically, I have seen the sorrow and hardship experienced by the families of those who lost their lives as well as the survivors. We need to heal their wounds.

The current military assignments of those remaining in Saudi Arabia also require that expanded provisions be made for PTSD and related disorders. The unhappy combination of PTSD with substance abuse is another area that additional funding must address.

VA funding must include in its list of priorities the compelling need for adequate PTSD research and clinical programs. The current VA experience in the area of PTSD has shown the synergism that exists between the research and clinical areas that must continue.

The Advisory Committee also recommends enhanced funding for health services research which allows for the review of research projects to address the outcomes and cost-effectiveness of medical care and the role and value of new technologies.

Finally, the recommendation of both the VA Health Research Policy Committee and the National Academy of Sciences in its 1977 review for the establishment of a Health Research Advisory Council to oversee all aspects of VA research is one I have commended to the Secretary. This could ensure an integrated and comprehensive consideration of clinical and research issues.

In closing, I would like to emphasize that, after careful review of the medical research program at the VA as mandated by Secretary Derwinski, the Advisory Committee for Health Research Policy has found that the research conducted at the VA is not only appropriate to the role of health care for veterans, it greatly improves the clinical care received at VA hospitals. Secondly, the medical research conducted at the VA serves to complement biomedical research conducted and supported by other federal agencies. Thirdly, VA medical research also helps to attract, train, and retain highly skilled physician-scientists.

However, the most troubling aspect of reviewing the VA medical research program has been the clear message that this program must receive additional funding. I am pleased to see in the draft legislation of this Subcommittee that several of the Advisory Committee's recommendations have been noted and incorporated. The recommendations for increased funding for FY 1992 are, I believe, essential to the continued success of VA research programs.

The support of the House VA Subcommittee on Hospitals and Health Care for the recommendations of the Advisory Committee on Health Research Policy, along with the dedication of the VA researchers to the VA mission, should result in improved care for the veterans of the United States and continued excellence in the training of physicians at VA medical centers. Thank you.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

on

The Veterans' Health Care and Research Amendments of 1991

presented by

Aram Chobanian, M.D.
Dean
University of Boston School of Medicine
Boston, MA

before the

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
U.S. House of Representatives
G.V. Montgomery, Chairman

334 Cannon House Office Building
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9:00 a.m.

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0525

Mr. Chairman and Members of the Subcommittee, I am Dr. Aram Chobanian, Dean of the Boston University of School of Medicine. It is a pleasure to appear before you this morning on behalf of the Association of American Medical Colleges (AAMC) to address the proposed "Veterans' Health Care and Research Amendments of 1991."

The AAMC serves as the national voice for the country's 126 accredited medical schools, over 90 professional and academic societies, and 420 major teaching hospitals (including 72 VA medical centers). Currently, 102 medical schools are affiliated with one or more VA facility. At my institution, we enjoy an affiliation with Boston VA Medical Center (Jamaica Plain) and the Edith Nourse Rogers Veterans Memorial Hospital in Bedford, MA. The Boston VAMC is the major referral center and full-spectrum tertiary care hospital for veterans in New England. More than 100 residents and a large number of medical students are assigned to the Boston VAMC. A Geriatric Research, Education, and Clinical Center (GRECC) is located at the Bedford VAMC. In addition, the School of Medicine has major affiliations with Boston's Causeway Street and Lowell's outpatient clinics.

The AAMC recognizes the important role the VA plays in providing health care to a special group of Americans as well as educating future health care providers and developing new knowledge. Thus, the Association is pleased to participate in a dialogue to consider proposals to improve the system as well as the development of new programs to help the VA fulfill its overall mission.

While the proposed legislation under review today covers a variety of issues, I will limit my remarks to the two sections that relate most directly to my professional inter-actions with VA operations. First, I will address the proposed research pilot program, and then I will comment on the proposal to enhance VA's ability to enter into joint equipment purchases. Following my prepared remarks, I will be happy to respond to questions about these matters as well as other items in the draft legislation.

With respect to the research pilot program, I understand that solicitation of proposals would only be authorized if the VA research program receives funding in excess of $260 million, and that awards would be made to support clinical research in the areas of mental health, substance abuse, and neurologic, psychiatric and geriatric rehabilitation. This proposal is in keeping with some of the recommendations of the 1990 VA Advisory Committee for Health Research Policy.

Academic medicine shares the view of this Subcommittee and that Advisory Committee about the importance and special mission of the VA research program. The VA does, and should continue to, focus research resources primarily in the areas related to the health care needs of veterans. Clinical research, health services research, and rehabilitation research are key components of that program. Projects in each of these areas have led to advances with immediate benefits to veterans and have improved the quality of care delivered by the VA. For example, the VA is nationally recognized as a pioneer in the field of geriatrics, symbolized by the VA's GRECC and the Geriatric Evaluation Unit programs.

The involvement of Boston University School of Medicine with the Bedford VAMC clearly demonstrates the clinical advantages that are associated with medical research. The hospital's primary mission historically involved the provision of psychiatric care, but with the introduction of the GRECC at Bedford in 1975, this emphasis shifted to a greater focus on geriatric medicine. In 1976, the hospital established the first unit in the nation dedicated to Alzheimer's Disease. In this center, the relationship between research and clinical activities has been synergistic. The research activities associated with Alzheimer's Disease have attracted physicians whose interests focus on the development of basic scientific knowledge as well as advancing clinical care. The number of publications and merit review research projects testifies to the excellent credentials of the GRECC research staff.

Whereas most nursing homes consider Alzheimer's Disease to be a condition rather than a disease, at Bedford veterans are given a full range of clinical care appropriate to their symptoms, coupled with support services for their families. As a result of the continuous counseling concerning both care and Alzheimer's Disease research, at the death of the patient, the family nearly always consents to an autopsy, understanding that diagnosis of Alzheimer's can only be confirmed through this procedure. As part of the coordinated care and research being done at the Alzheimer's Disease Center, families can then receive genetic counseling. Future plans for the Center include using autopsy data to assist other researchers in clinical trials, geneticists in search of linkage, and molecular biologists to identify gene patterns. Thus, the knowledge gained through autopsies is used to help families further, improve clinical care, and compliment other Alzheimer's Disease research.

Other research being conducted at the GRECC will have a significant impact on our understanding of Alzheimer's Disease, its symptoms, and its causes. One current study is aimed at better understanding various forms of dementia, with a focus on Alzheimer's Disease and the possibility that this disease might have several forms and causes. Results should improve diagnosis, basic knowledge about, and care for Alzheimer's Disease. Another study is examining the effects on the brain of most disease processes, including seizure disorders, mental retardation, strokes, head trauma, and degenerative diseases such as Huntington and Alzheimer's Diseases. If we are going to discover clues to recovery for these diseases, it will only come through knowledge of the normal connections at every level of the central nervous system. The basic information these studies provide has far ranging implications for the treatment of several disease states.

The relationship between research and clinical care has been demonstrated again by continuing success in recruiting talented young physicians into the facility's program that is now integrated with the geriatric center at Boston University Medical Center. More than twenty physicians have completed or are currently involved with the geriatric fellowship program.

Recently, a major Center of Excellence involved in the development of a new system of care for elderly patients has been funded at Bedford. The major directions of the Center proposals include:

(1) Expansion of ambulatory/community care liaisons for early identification and support of frail elderly veterans in an ambulatory status, providing continuity between institutional and extra institutional care.

(2) Integration of psychiatric behavior medical care. Geriatrics is heavily involved with behavioral, emotional, and central nervous system problems in patients increasingly compromised by systemic diseases.

(3) Focus of hospital care on the episodic acute care needs of the population of patients already under long-term care management by VA programs.

(4) Integration of the GRECC's programs more closely with the clinical program in research, training, and patient care.

Specific program components include the establishment of a specialized hospital-based home care program, expansion of community residential care, establishment of an intensified ambulatory treatment center, development of an enhanced respite care program, utilization of the case management model in ambulatory care, and creation of a veterans' community care center.

By no means is all research of the Boston University School of Medicine faculty conducted at Bedford. Important projects relevant to the particular interests of this Committee and related to the pilot program proposal are ongoing at both the West Roxbury and Boston VAMCs. Of particular note is the Memory Disorders Research Center at the Boston VAMC. The main purpose of the Center is to study the relationship between memory disorders and brain injuries. Researchers are studying what types of memory exists, and how they are damaged by diseases, strokes, traumas, tumors, and alcohol abuse. In addition to assessment and subsequent counseling for the veterans and their families, the Center will provide appropriate therapies, including computerized procedures to help the veteran overcome memory disorder. Researchers at the Boston VAMC are also studying recovery patterns in diseases related to alcoholism, specifically liver disease, to assess treatment utilization by veterans who seek treatment for alcohol-related conditions. Other alcohol-related research involves a study of drinking among aging, community-dwelling male veterans to determine the factors influencing their drinking and recovery.

At Boston University School of Medicine, we are very proud of the contribution of our faculty to the care and research benefitting veterans at the three excellent VA facilities with which we are affiliated. The enduring result of this relationship is the quality of care for a severely impaired veteran population and the training of young physicians committed to enhancing the delivery of care to the elderly citizens of our country.

The AAMC has traditionally opposed designating funds for particular areas of research or specific projects because such an approach can limit the likelihood of funding for the grant proposals that are deemed most meritorious, based on the peer review process. However, the AAMC recognizes that some guidance is appropriate in outlining the general nature of a Federally-sponsored research effort. While the Association would object to a directed approach for the entire VA research program, we support the notion of prioritizing areas of investigation as a limited pilot program, if adequate funds are available, so long as the pilot program compliments the underlying mission of the agency, and the pilot program does not compete with the broad nature of the established program. The pilot program outlined in the draft legislation appears to both support the overall mission of the VA and to expand, but not detract from, the existing VA research program.

If I may, I would like to take a moment to thank the Chairman and Members of the Subcommittee for their advocacy on behalf of increased funding for the VA research program. To support your efforts, the AAMC and the coalition of organizations known as the Friends of VA will work with the Budget and Appropriations Committees to convey the message about the importance of providing an adequate budget for VA medical care and research.

The AAMC also supports without modification the section of the proposal that would "authorize the VA to procure medical equipment, title to which would be held jointly with any health care facility which provided VA with at least half the purchase price of that equipment, under arrangements where the parties have agreed to share in the use of such equipment." The AAMC recognizes that because of location and a variety of other factors, not all VA facilities will be able to negotiate such an arrangement with another facility. However, when feasible, in this era of increasing specialization, shared equipment makes good sense fiscally and clinically. In cases where patient care demands cannot warrant the purchase of certain sophisticated equipment, jointly held and utilized resources will make available the advantages of high technology to veterans and other hospital patients. To meet the challenge of delivering advanced health care in rural settings, shared equipment holds promises for bringing many benefits to remote and sparsely-populated communities.

Under current law, sharing of equipment is authorized, but the private sector faces disincentives to entering into an agreement with the VA. First, the private institution's portion of the capital to purchase a piece of equipment must be made in advance as a "gift contribution" to the VA. In other words, the private entity loses the ability to earn interest on that capital during the often lengthy VA procurement process. Following purchase, the private entity is limited in its ability to depreciate the costs of equipment shared with the VA. The proposed legislation is an improvement over current law because it allows the private party to hold purchase funds in an escrow account, earning interest, until the time of purchase. In addition, since both parties will share the title, the private entity will be permitted a portion of the depreciation allowances.

Thank you, Mr. Chairman, for the opportunity to present my views on the "Veterans' Health Care and Research Amendments." I will be happy to expand on any points addressed in my testimony or to comment on issues that I did not have time to address.

American Federation for Clinical Research

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STATEMENT REGARDING FY 1992 FUNDING FOR THE DEPARTMENT OF VETERANS AFFAIRS RESEARCH PROGRAM

Presented by

Dr. Richard Cohen
Professor of Medicine and Physiology
Boston University School of Medicine

and

President
American Federation for Clinical Research

Before the

Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
U.S. House of Representatives

April 10, 1991

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My name is Richard Cohen. I am professor of medicine and physiology at Boston University School of Medicine and the president of the American Federation for Clinical Research (AFCR). I am pleased to appear before this Subcommittee to express the AFCR's views regarding FY 1992 funding for VA health research. The AFCR is an organization of approximately 13,000 physician scientists, many of whom are based in VA hospitals, where they provide care to patients and receive support for their research. For the last several years, the AFCR has been concerned about the lack of adequate funding that the research program receives. This year, we are particularly disturbed.

In January, a Blue Ribbon Panel, commissioned by the Secretary of Veterans Affairs and made up of distinguished scientists, economists and past policy makers, concluded after extensive study that the VA research program is inadequately funded. The panel found that the program does excellent research, greatly improves the care available to veterans and is a crucial factor in the recruitment and retention of high-quality doctors to the VA. The panel also concluded that the research program "is inadequately supported to achieve its goals," and recommended an FY 1992 budget of $280 million. The AFCR supports the panel's conclusions and would like to expand on several of its points.

As the Blue Ribbon Panel points out, the "quality of VA research is exceptionally high" and "essential to provide the best care for veteran patients." The VA continues to uncover treatments and cures that both improve the health of veterans and save money for the VA and for our entire health care system. Recent accomplishments include the following:

o A VA researcher recently found a way to control weight loss in the elderly enabling them to fight osteoporosis and other age-related disorders. Addressing disorders of the elderly is crucial for the VA because the number of veterans over 65 will almost double in the next 30 years, reaching 7.7 million by the year 2020.

- A recent VA-conducted study uncovered a new treatment for chronic hepatitis B, a debilitating liver disorder which can be fatal. Treatment with interferon therapy halted or completely cured almost 40 percent of veterans treated. Each year, 60,000 veterans develop liver disorders.
- A VA-sponsored study revealed that many veterans with prostate enlargement could be treated without surgery. Use of this non-surgical procedure could save the VA up to $29 million annually.
- Research at the VA showed veterans treated in geriatric evaluation units (GEUs), facilities designed to improve hospital care for frail, elderly patients, have much lower mortality rates and fewer discharges to nursing homes than those given standard care. After establishing GEUs in each of its hospitals, the VA predicts 200,000 fewer nursing home admissions annually, saving the VA $11 billion each year.

The VA research program continues to focus on those conditions that primarily affect veterans. Also, through the presence of a research program, veterans are given the opportunity to participate in cutting-edge therapies not yet available to the general public, such as the latest AIDS drugs and therapies to treat Alzheimer's disease.

Another crucial element of the research program is its ability to attract excellent physicians to VA hospitals. The VA, where the salaries, equipment and overall environment are far below that in other care settings, is able to attract high-quality doctors by giving them the opportunity to conduct research as well as care for patients. As the Blue Ribbon Panel concluded in its report:

> Since the VA has a vigorous research program, which is essential to provide the best care for veteran patients, the system is able to attract a high-quality house staff and attending physicians. These two elements combined -- the high quality staff and the research driven care --

> enable the VA to provide superior services that could not be purchased in the private sector.

Unfortunately, as the panel's report points out, the program "is inadequately supported to meet its goals." As research opportunities diminish -- only 40 percent of approved projects will be funded this year compared to 80 percent funded in FY 1985 -- many physicians have begun to question careers in the VA. In fact, the AFCR has learned of many physicians who, after years of being funded, are now denied support for their high-scoring projects due to severe budget constraints. We have seen this situation all over the nation -- from California to Mississippi to Massachusetts to Georgia. Physicians, who have been in the VA for years and who are dedicated to finding better treatments to care for veterans, can no longer get funding for their meritorious projects. After several years of this situation, these doctors have become extremely discouraged and are beginning to look elsewhere to pursue their careers. It will be a terrible state of affairs if veterans can no longer benefit from the superior care that these physicians offer.

In order to address the compounded problem of several years of underfunding, the Blue Ribbon Panel recommended an FY 1992 VA research budget of $280 million. This level would fund 1,840 research projects, 227 career development awards and 26 cooperative studies -- roughly the same number as were funded in FY 1985. The panel's recommendation of $280 million is not unrealistic because it would merely restore the research program to the level of effort provided in FY 1985 before serious budget cuts took place.

Extensive study went into formulating these recommendations, developed by a panel specifically commissioned by the Administration to examine the program. Therefore, we were surprised and dismayed that the very Administration that asked for these recommendations appears to have ignored them. For FY 1992, the Bush Administration requests $216.8 million for VA research -- $63 million less than the Blue Ribbon Panel advised and the same budget as appropriated in FY 1991. We question why the panel was formed if its recommendations were not to be heeded. The AFCR supports the findings of the Blue Ribbon Panel and hopes Congress can see to it that they are followed.

Thank you for considering the opinions of the American Federation for Clinical Research.

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

DRAFT LEGISLATION TO IMPROVE AND ENHANCE VA HEALTH CARE AND THE VA HOME IMPROVEMENT GRANT

WASHINGTON, D. C. APRIL 10, 1991

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I wish to extend the appreciation of the 2.2 million members of the Veterans of Foreign Wars of the United States for having invited our participation in today's important legislative hearing. The Department of Veterans Affairs (VA) medical care program is this nation's largest integrated health care system, and provides an invaluable service to many of this nation's deserving veterans. Indeed, if it were not for the VA medical care program, many veterans would have little, if any access to health care. Thus, we are both pleased and honored to take part here in today's forum, directed toward improving the health care provided to veterans by VA.

Under discussion today is draft legislation to codify and expand VA's Advance Medical Technology/Shared Procurement Program; make improvements in VA's child care program; extend the VA's authority to establish nonprofit research corporations; establish a pilot program to improve the provision of clinical care through research; expand post-traumatic stress disorder (PTSD) and homeless chronically mentally ill programs subject to the availability of resources; increase the VA home improvement/structural alteration grant limits; and, other legislative proposals. We will address these provisions, Mr. Chairman, in the order that they are contained in the draft legislation which you have provided to us for review.

First under discussion is a provision to authorize VA to provide outpatient dental treatment when medically necessary to prepare a patient for hospital admission, or for a veteran receiving VA care or medical services. The VFW strongly supports this provision which we view as being both compassionate and cost effective. We would point to the fact that the current prohibition against outpatient dental treatment by VA prevents the timely provision of care to certain veterans, resulting in the unnecessary worsening of their disabilities. This causes undue suffering and harm to these veterans and additional costs to VA.

Next under consideration is the provision to increase from $500 to $1,000 the threshold set under title 38 above which proposed fee-basis dental treatment must be subject to a second opinion. The VFW supports this proposal inasmuch as it would bring this threshold more in line with medical inflation and the current cost of dental care.

Next to be addressed is a provision to amend 38 United States Code (USC) sec 603(a)(1) to authorize fee-basis treatment or contract hospitalization for any disability of a veteran who has a total disability permanent in nature from a service-connected disability. The VFW supports this proposal inasmuch as we view it as highly appropriate that 100 percent totally and permanently disabled veterans would have immediate and unhindered access to all forms of medical care even when it is beyond the range of VA's own inhouse capability.

Also under discussion today is a provision to extend through fiscal year 1992 the reporting requirement in section 19011(e) of Public Law 99-272 regarding furnishing a of health care. The VFW supports this proposal.

The next provision we will address is one to extend through September 30, 1992, VA's authority, contained in section 632(a), to contract with the Veterans Memorial Medical Center to provide for care of veterans. The VFW supports the extension of this authority to provide for payments for hospital care and medical services to United States veterans at the Veterans Memorial Medical Center in the Republic of the Phillipines.

Next under discussion is a proposed requirement that, after the date of enactment, social workers employed in the Veterans Health Administration hold a master's degree in social work and, if the law of the State of employment so requires, be licensed, certified, or registered, except that the Secretary may waive the latter requirement for up to three years to allow completion of State requirements. Also proposed is the requirement of a two year service obligation for participants in the Health Professional Scholarship Program. The VFW supports these proposals.

Next under consideration is a proposal to authorize the Secretary to provide promotional items of nominal value for recruitment purposes. In light of the tremendous competition between the private sector and VA to recruit qualified health care personnel, the VFW supports this proposal.

Next under consideration is the proposal to amend section 5004 of title 38, to provide that funds may not be appropriated or expended for any major medical project or major medical facility lease unless funds for such project have been specifically authorized; and to reduce from $500 to $300 thousand the threshold of what constitutes a major medical facility lease. The VFW has no objection to this proposal to enhance the ability of the Congress--with special emphasis on the Veterans' Affairs Committees--to ensure the equitable distribution of medical facilities throughout the United States.

Next under review is the proposal to provide that reports issued by the VA's Geriatric and Gerontology Advisory Committee be submitted simultaneously to the Secretary and the appropriate congressional committees. The VFW has no objection to this proposal.

The next proposal would require, subject to the availability of appropriations, the establishment of a pilot program of medical research to improve provision of clinical care in VA facilities. The bill would call for the Secretary to solicit proposals from VA medical centers for the conduct of research applicable to clinical care in the areas of: mental illness, alcohol and substance abuse; and, neurologic, psychiatric, and geriatric rehabilitation. To be eligible for such funding, a medical center must have entered into an agreement with a medical school or other institution described in section 4101(b) under which that entity agrees to provide partial funding or in-kind support for the proposed research. In awarding funding from among those proposals deemed meritorious under a peer review process, the Secretary must give priority to those proposals deemed to offer the greatest contribution to improving the quality of clinical care at the medical center. For purposes of this provision, the terms "subject to the availability of appropriations" shall mean the appropriation for fiscal year 1992 of no less than $43 million above the President's appropriation request for fiscal year 1992 (as submitted to the Congress in February 1991) for the medical and prosthetic research account; and for fiscal years 1993 and 1994 an appropriation of $____ million and $____ million respectively above the level of the FY '92 appropriation. The provision would authorize the appropriation of up to $6 million in fiscal year 1992, 1993, and 1994 for the pilot program. The VFW supports the establishment of this pilot program and further congratulates the Committee for its sound judgement in making the establishment of such a program contingent upon the provision of the requisite appropriations dollars over and above that requested by the Administration. VA is now extremely hard-pressed to fulfill its mandates under current law and establishing additional requirements without providing the dollars to carry them out would constitute a disservice to all veterans.

The next provision under discussion would amend section 617 of title 38 to raise the limit on Home Improvement Structural Alteration (HISA) grants to $3,300 and $1,200, respectively. These grants provided to service-connected disabled veterans allow for the provision of home health services as well as improvements and structural alterations to the home which are necessary to assure the continuation of treatment for the veterans disability or to provide access to the home or to other essential lavatory and sanitary facilities. The VFW strongly approves the proposed increases inasmuch as it would bring these grants more in line with current costs.

Next under discussion is a provision to clarify that, notwithstanding any other law, the Chief Medical Director has exclusive authority to set standards for, and assure consistent performance of, VA laboratory facilities. The VFW has no objection to this proposal.

The next provision under consideration would extend by one year the period within which VA research corporations must secure tax exempt status and the "sunset" date for establishment of such corporations. VFW supports this provision inasmuch as such a research corporation would serve as an important asset toward the provision of improved veterans' health care.

Next under consideration is a proposal to authorize the VA to procure medical equipment, title to which would be held jointly with any health care facility which provided VA with at least half the purchase price of that equipment, under arrangements where the parties have agreed to share in the use of such equipment. The measure would limit VA payment for such jointly-owned equipment to a maximum of one-half the purchase price, and provide for VA to deposit funds received from its sharing partner in an escrow account to be disbursed upon delivery of the equipment. It would require the partner to pay its share of the purchase price of the equipment--such money to be placed in the escrow account--before VA enters into a procurement contract, but would specifically authorize the investment of such escrowed funds in obligations of the Federal Government of federally insured or guaranteed instruments, and the disbursement of the sharing partner of interest earned on the sharing partner's fund. It would also authorize the VA to transfer VA's interest in the equipment to the joint owner under certain circumstances and require payment to VA of one-half the depreciated purchase price. The VFW generally supports this provision as a potentially valuable tool for providing certain specialized high-cost care to veterans. We would only urge that any interest earned by VA through its escrowed funds be retained and utilized to procure medical equipment and that these funds not in any way be offset against VA's appropriation. We would also urge that any amounts received by VA from its sharing partner in the event the sharing partner purchases shared equipment to also be retained by VA with no reduction in its appropriation.

Next under consideration is a proposal to expand VA's authority to provide child care services by amending section 4209 to permit operation of centers under the auspices of Veterans Canteen Service (as provided under existing law), or through any other appropriate office of the Department or through contractural arrangements. The measure would require that the establishment and operation of such a center be determined to serve the Department's best interests. A center established under this authority must assure that highest priority for enrollment will be given Department employees, second priority to other employees of the Federal government, and third priority to other employees of affiliated schools and VA research corporations. To the extent space is available, VA may offer enrollment to others. The bill would authorize the establishment of preferential rates for VA employees and the establishment of different charges for enrollment for each priority group. The measure would also call for VA to assure that in setting charges, the sum of all payments must be sufficient to meet staffing costs, at least, although such charges could also take account of the costs of establishing the center as well as services that VA provides the center. Proceeds from charges would be credited to the applicable VA account and allotted to the applicable VA facility, to remain available until expended. The bill would authorize VA to construct or alter space in any VA facility, or to lease space, for use as a child care center. It would also permit VA to provide, out of operating funds, items and services necessary for the operation of the center. In light of the extreme difficulty facing some VA facilities in attracting certain health care professionals, and that many of these health care professionals have dependent children, the VFW supports this proposal as being appropriate, compassionate and, indeed, prudent.

Next under consideration is the establishment of the requirement, subject to the availability of appropriations, that VA during fiscal year 1992 establish and operate at such locations as the Secretary deems appropriate not less than five new specialized inpatient PTSD units, 10 new PTSD clinical treatment teams, and five outpatient programs for the treatment of veterans suffering from both PTSD and substance abuse problems. (The bill would specify that the terms "subject to the availability of appropriations" means, for purposes of this section and a section on homeless programs, the appropriation for fiscal year 1992 of no less than $225 million above the President's appropriation request for fiscal year 1992 for the medical care account and $_____ million above the request for the medical administration and miscellaneous operating expenses.) The measure would authorize the appropriation of $7.4 million for the operation of the new PTSD treatment programs. The bill would also direct that VA designate a level of funding support for, and assign a priority to, the conduct of research on mental illness, including research on PTSD, PTSD in association with substance abuse, and the treatment of those disorders. In furtherance of such effort the bill calls for the Secretary to solicit research proposals from VA medical centers for the conduct of research in those areas, and for the award of grants in accordance with procedures prescribed by the Chief Medical Director, to include a peer review process. The bill would also call for the VA to conduct a needs assessment on, and prepare a strategic plan for, the provision of PTSD care--based on reasonable availability of a continuum of care--to category "A" veterans, and to provide a report to the appropriate Committees of the Congress within one year after enactment of this measure. In light of the severe on-going mental suffering endured by certain veterans of past wars, the VFW supports this proposal to enhance and expand the care provided to veterans suffering from post-traumatic stress disorder. We also once again commend the Committee for making the establishment of these programs contingent upon the provision of appropriate funding.

The next provision under consideration would require that VA, subject to the availability of appropriations (as defined above), expand its homeless chronically mentally ill (HCMI) program by augmenting staff at sites in those cities with the greatest need and adding new programs in four cities with the greatest unmet need. The bill would also require the establishment of a pilot program for the care of homeless veterans to include outreach to veterans through the use of vans or other means of transportation, provision of medical care, and transitional housing. An essential component of the pilot program would be the concept of cost-sharing with a public or private entity, with VA paying no more than 75 percent of the cost of services provided under the program. The bill would authorize the appropriation of an additional $3.25 million for the HCMI program and $300, 000 for the pilot program. Contingent upon the provision of the required appropriations dollars, the VFW would support the establishment of these proposals to assist this nation's homeless and mentally ill veterans. This, the greatest nation on earth, must not allow its mentally ill veterans--those who have suffered and sacrificed on behalf of the common good--to suffer alone and unattended, under the worse kind of poverty.

The last proposal under discussion today would authorize the Secretary to accept donated land for the purposes of acquiring and operating veterans medical facilities as well as for VA Regional Offices. The VFW supports this proposal.

Mr. Chairman, I wish to once again thank you and the other members of this distinguished Subcommittee for having invited the participation of the Veterans of Foreign Wars in today's important legislative hearing. The VFW shall remain committed and vigilant with respect to the improved operation of the nation's veterans' health care system. This concludes my statement, I would happy to respond to any questions you may have. Germane resolutions are appended to this statement.

Resolution No. 614

CATEGORY "A" VETERANS ENTITLEMENT TO OUTPATIENT CARE

WHEREAS, a sound medical program emphasizing preventive care is best accomplished by access to outpatient treatment; and

WHEREAS, certain Category "A" veterans are entitled to outpatient care under the means test; and

WHEREAS, the majority of nonservice connected veterans are entitled only to inpatient care and, therefore, can be expected to delay seeking help until a condition deteriorates to a potentially life threatening level requiring inpatient care; and

WHEREAS, large numbers of those nonservice connected veterans classified as Category "A" are the most needy of the veteran population; now, therefore

BE IT RESOLVED, by the 91st National Convention of the Veterans of Foreign Wars of the United States, that all veterans classified as Category "A" be entitled to outpatient treatment by the Department of Veterans Affairs.

Adopted by the 91st National Convention of the Veterans of Foreign Wars of the United States, held in Baltimore, Maryland, August 17-24, 1990.

Resolution No. 614

Resolution No. 741

TO PROVIDE ADEQUATE VA HEALTH CARE BUDGET

WHEREAS, in adequate VA budgets over the past ten years have resulted in drastic reductions in facilities and capabilities of VA hospitals, nursing homes, domiciliaries and outpatient treatment centers, etc.; and

WHEREAS, the current quantitative and qualitative deterioration of available veterans care is directly attributable to these budget reductions; and

WHEREAS, the rapidly advancing average age of our veteran population is accompanied by a proportional escalation in their health care requirements; now, therefore

BE IT RESOLVED, by the 91st National Convention of the Veterans of Foreign Wars of the United States, that we petition the Congress of the United States to provide a VA budget which will ensure adequate staffing and funding of VA hospitals, nursing homes, domiciliaries and outpatient facilities to provide for our veterans future health care needs.

Adopted by the 91st National Convention of the Veterans of Foreign Wars of the United States, held in Baltimore, Maryland, August 17-24, 1990.

Resolution No. 741

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE HOUSE COMMITTEE ON VETERANS AFFAIRS
APRIL 10, 1991

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.3 million members of the Disabled American Veterans and its Ladies' Auxiliary, may I say how very much we appreciate the opportunity to appear here today and offer our views regarding proposed draft legislation -- the "Veterans' Health Care and Research Amendments of 1991" -- affecting the Department of Veterans Affairs (VA) Veterans' Health Services and Research Administration (VHS&RA).

It is necessary to state at the outset, Mr. Chairman, that as proposed legislation has not yet been drafted we would like to reserve our right and privilege of offering additional comments at a later date.

Mr. Chairman, the DAV is generally supportive of the proposals regarding VA dental treatment that would provide outpatient dental treatment when medically necessary to prepare a veteran for hospital admission, or for a veteran receiving VA care or medical services; and amend Section 612(b)(3) Title 38, USC, increasing from $500 to $1,000 the threshold above which proposed fee-basis dental care must be subject to a second opinion.

We fully support the proposal to amend Section 603(a)(1), Title 38, USC, authorizing fee-basis or contract hospitalization to be provided for any disability of a veteran who has a service-connected disability total and permanent in nature.

Favorable consideration and ultimate enactment of this provision would correct an unanticipated and unintended -- Section 19012 of P.L. 99-272, the "Consolidated Omnibus Budget Reconciliation Act of 1985" -- but nevertheless prevailing requirement that is totally restrictive in nature concerning the manner in which 100 percent, totally disabled service-connected veterans are permitted to receive non-VA health care services at VA expense. (Additionally, enactment of this measure would serve to partially satisfy DAV Resolution No. 303, copy attached).

The DAV has no official position regarding the proposal to extend, through September 30, 1992, the VA's authority to contract for the care and treatment of veterans by the Veterans' Memorial Medical Center of the Republic of the Philippines.

The proposal that would require social workers employed by the VA to possess a master's degree in social work and, if so required by state law, be licensed, certified, or registered, with certain waiver provisions available by the Secretary seems, in our view, designed to strengthen the quality of care provided to veterans. As such, we have no objection to its favorable consideration.

Mr. Chairman, the DAV has always been supportive of any reasonable proposal that would ease the serious recruitment and retention problems empirically experienced by VA concerning the employment of an adequate number of qualified health care providers, especially nurses.

Having so stated, we are supportive of the proposal to require a two year service obligation -- versus the current requirement of one year service for one year of scholarship assistance provided -- for those participants in the Health Professional Scholarship Program.

Mr. Chairman, we do not, as yet, have sufficient information enabling us to state a position regarding the proposal to authorize the Secretary to provide "promotional items" in conjunction with recruitment purposes.

Mr. Chairman, we have no official position regarding the proposal to amend Section 5004 Title 38, USC, providing funds may not be appropriated or expended for any major medical project or major medical facility lease unless funds for such project have been specifically authorized; and, to reduce from $500,000 to $300,000 the threshold of what constitutes a major medical facility lease.

However, it would be our hope that as the Subcommittee considers this proposal the issue of VA accountability and the need to retain a degree of flexibility in the leasing process be carefully considered.

Mr. Chairman, the DAV strongly supports the proposal that would require that reports issued by the VA's Advisory Committee on Geriatrics and Gerontology be submitted simultaneously to the Secretary and to the appropriate Congressional committees.

Mr. Chairman, in January 1990, Secretary Derwinski established and appointed the Department of Veterans Affairs Advisory Committee for Health Research Policy. In so doing, the Committee was asked to address the following questions:

- Is VA research appropriately balanced among health research subject areas?
- Is VA research appropriate to the role of the VA in providing medical and other health care services to veterans?
- Is the VA research program appropriate vis-a-vis the role of other federal agencies, including NIH?
- What is the overall quality of the VA research program?

Additionally, the Committee was subsequently requested, by the Secretary, to recommend a budget for VA's research program for FY 1992.

In response to the last charge the Committee recommended, in part:

> "To achieve this goal, the Committee recommends FY 1992 funding for the medical research program of $235 million and for the total health research program of $280 million.
>
> (2) In addition to continuing to strengthen aging and geriatric research, several areas should be targeted for special enhancement as part of the general effort to rebuild the level of VA research to meet its current needs and for ongoing review by the proposed Health Research Advisory Council. These include the following:
>
> (a) Development of new research initiatives on mental illness and substance abuse. As recommended earlier in

> this report, a well considered and coordinated program of Mental Illness Research, Education and Clinical Care Centers (MIRECCs), supported by adequate program development staff, could go a long way in improving the recruitment and clinical expertise of investigators concentrating on mental illness and addictive disorders.
>
> (b) Expansion of Rehabilitation Research to include cardiovascular, neurologic, psychiatric, and geriatric rehabilitation research to enhance the VA's effectiveness in rehabilitating veterans whose needs are psychosocial or physical rehabilitation while complementing the outstanding investigative efforts already underway in prosthetics and orthotics."

Mr. Chairman, your draft proposal establishing a pilot program of medical research for the purpose of improving the provision of VA clinical care clearly and precisely meets the intent of the Advisory Committee's recommendations and has the full support of the DAV.

We realize VA now has authority to conduct the research programs contemplated by this proposal. However, it is our firm belief that VA needs to be focused in the type of research it conducts and sponsors that has the ultimate goal of improving the lives of veterans and the general population as whole.

Our support of the draft proposal recognizes a continuing eroding resource base of VA research programs and the fact VA must dedicate resources to those areas that will most benefit veterans and veteran related issues.

Mr. Chairman, we applaud your recognition of the fact that the VA's Home Improvements and Structural Alterations (HISA) grants -- Section 617 (a)(2), Title 38, USC -- have not been increased over the last 15 years.

We fully support the proposed increase -- from $600 to $1,200 for nonservice-connected disabled veterans and certainly are appreciative of the proposed increase from $2,500 to $3,300 for service-connected veterans -- for the one time grant for structural modifications of the home as part of home health services for serious disabled veterans. We would respectfully urge, however, the Subcommittee consider the maximum limitation of $5,000 for service-connected disabled veterans as recommended by the Independent Budget.

Mr. Chairman, we are generally supportive of the perceived intent of the proposal authorizing the joint procurement of medical equipment between VA and non-VA health care facilities.

Certainly, the issue of VA's equipment backlog is not new to the Subcommittee. In FY 1990 the estimated cost to simply replace outdated medical equipment with new equipment was $1.2 billion. Most VA medical centers recently reported backlogs of needed but unpurchased medical equipment ranging from $1 million to $8 million. Such a situation makes it difficult if not impossible to continue to provide state-of-the-art, as well as quality medical care.

Prior to extending our full support for this proposal we believe additional clarifying language and safeguards may well be needed.

For example, we are concerned as to where such equipment would be located; how the allocation of patient usage and time would be equated; what proportion of the installation costs would be borne by each partner; and, how construction costs, if any, would be addressed.

Also, Mr. Chairman, we are concerned as to how and under what circumstances VA would deem it necessary or beneficial to transfer title of any equipment to the participating partner.

As I stated earlier, Mr. Chairman, the DAV has always been supportive of those proposals seeking to assist VA in the recruitment and retention of qualified health care providers.

Therefore, we are certainly supportive of the intent of the proposal to amend Section 4209, Title 38, USC, expanding VA's authority to provide child care services by permitting the operation of child care centers through the Veterans' Canteen Service, or through any other appropriate office of the VA, or through contractual arrangements. It appears that additional flexibility is being provided by the proposed changes which we believe will greatly benefit local VA facilities in carrying out their mandated mission of providing quality health care services to disabled veterans.

Mr. Chairman, the draft legislation pertaining to the issue of Post Traumatic Stress Disorder (PTSD) proposes a number of very meaningful and, we believe, needed improvements in the way VA deals with this issue.

Specifically, the bill would:

- Establish not less than five new specialized inpatient PTSD units;
- Establish not less than ten new PTSD Clinical Treatment Teams (PCTs);
- Establish not less than five outpatient programs for the treatment of veterans suffering with both PTSD and substance abuse;
- Authorize the appropriation of $7.4 million for the operation of these new treatment programs;
- Direct VA to conduct research on PTSD; PTSD in association with substance abuse; and in the treatment of PTSD;
- Require the Secretary to solicit research proposals from VAMCs and award grants for the conduct of such research; and,
- Require VA to conduct a needs assessment and prepare a strategic plan for the provision of PTSD care to Category A veterans; and report to Congress the results of their efforts in these regards.

Mr. Chairman, the DAV is supportive of the proposals concerning PTSD.

The draft legislation contemplates proposals aimed at enhancing the VA's programs of assisting homeless veterans.

Specifically, expansion of the Homeless Chronically Mentally Ill Program (HCMI) would occur by adding staff at existing program sites and adding four new programs.

Additionally, a pilot program would be established to include:

- Outreach services through the use of vans or other means of transportation;
- Provision of medical care; and,

- Establishing transitional housing.

An integral part of the pilot program would be cost sharing with a public or private entity, with VA paying no more than 75 percent of the cost of the program.

Finally, the measure would authorize the appropriation of an additional $3.25 million for the HCMI program and $300 thousand for the pilot program.

Mr. Chairman, the provisions dealing with homeless veterans, as well as the provisions dealing with the pilot program of medical research and the enhancement of the treatment of PTSD are all "subject to the availability of appropriations" for Fiscal Year 1992.

Certainly the DAV is aware of and vitally concerned with the current budgetary climate. The DAV has been dollar conscious and, I believe, fiscally responsible in our pursuit of a meaningful legislative agenda over the years. It is no different today.

In that very regard, Mr. Chairman, the Independent Budget has addressed the budget deficit head on. As a result, we have outlined what we believe to be very reasonable and attainable goals and methods that formulate an alternative deficit reduction plan with the potential of exceeding the assigned reconciliation targets as contained in the Omnibus Budget Reconciliation Act of 1990.

Mr. Chairman, I mention the above only for the purpose of recognizing that the DAV is painfully aware of the pay-as-you-go provisions that we all must be considerate of in discussing legislative proposals and program enhancements. However, there are certain entitlements, issues and areas of health care that are so intrinsically linked to the direct performance of military service that they should constitute a priority area of treatment for the VA.

Consequently, we believe there must be a firm recognition and commitment to the philosophy that certain types of care constitute a priority and should not be made available to veterans subject only to the availability of additional appropriations before such care is provided.

Finally, Mr. Chairman, we have no official position regarding proposals that would:

- extend, through FY 1992, the reporting requirements of P.L. 99-272 regarding furnishing of health care;
- extend, by one year, the period within which VA research corporations must secure tax exempt status; and extend the "sunset" date for establishment of such corporations; and
- authorize the Secretary to accept donated land before title of the property is approved by the Department of Justice.

This completes my testimony Mr. Chairman, and I would be pleased to respond to any questions you or members of the Subcommittee may have.

RESOLUTION NO. 303
LEGISLATIVE

TO AMEND SECTION 603, TITLE 38, USC, REGARDING VA CONTRACT HOSPITALIZATION

WHEREAS, Public Law 99-272, the Omnibus Budget Reconciliation Act of 1985, statutorily mandates the Department of Veterans Affairs to furnish service-connected disabled veterans with needed inpatient health care services; and

WHEREAS, needed health care services are required to be provided in a Department of Veterans Affairs medical center, a Department of Defense medical facility or, in a non-federal, private hospital under VA contract, if the veteran is in need of immediate care; and

WHEREAS, Section 603, Title 38, USC, is limited and restrictive concerning which veterans may be authorized contract hospital care; and

WHEREAS, this provision places service-connected disabled veterans in jeopardy of being denied required medical services; NOW

THEREFORE, BE IT RESOLVED that the Disabled American Veterans in National Convention assembled in Anaheim, California, July 29-August 2, 1990, support legislation to amend Section 603, Title 38, USC, to permit the Department of Veterans Affairs to furnish contract hospital care to those service-connected disabled veterans as identified in Section 610(a)(1) when required.

* * *

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
APRIL 10, 1991

Mr. Chairman and Members of the Subcommittee:

The American Legion wishes to thank you for this opportunity to share its views with you on the draft legislation regarding various Veterans Health Services and Research Administration (VHS & RA) programs. We respectfully request the prerogative to further comment on subjects included in the draft legislation, the "Veterans Health Care and Research Amendments Act of 1991", when the bill is introduced.

With regard to provisions of the draft bill dealing with outpatient and fee-basis dental eligibility treatment, The American Legion supports the proposal to provide outpatient dental treatment when determined as medically necessary to prepare a patient for hospital admission, or for a veteran already receiving VA care or medical services. Outpatient dental treatment, according to the proposed measure, would remain provisional for nonservice-connected dental conditions, unless it is medically determined that such treatment would provide proper standards of care for adjunct medical conditions. The American Legion supports increasing from $500 to $1,000 the threshold set in title 38, United States Code, section 612 (b)(3), above which proposed fee-basis dental treatment must be the subject of a second opinion. We believe this measure maintains an atmosphere of fiscal responsibility in as much as costs of obtaining fee-basis dental treatment continues to rise and costs for certain dental procedures may vary in different geographical areas.

The American Legion supports the provision of the draft bill to amend section 603(a)(1) of title 38, United States Code, to authorize fee-basis treatment or contract hospitalization for any disability of a veteran who has a total disability permanent in nature from a service-connected disability, provided that care is not available at nearby VA medical facilities or creating hardship for the veteran. Also, we favor the measures contained in the draft bill to extend through fiscal year 1992 the reporting requirement of section 19011(e) of Public Law 99-272, which directs VA to furnish the Committees on Veterans Affairs with an annual report regarding the composition of health care furnished to eligible veterans. Additionally, we strongly support the draft provision to extend through September 30, 1992, VA's authority (in section 632(a) of title 38, United States Code) to contract with the Veterans Memorial Medical Center, Republic of the Philippines, to provide for care of eligible veterans.

Mr. Chairman, The American Legion offers no objection to provisions of the draft bill which provide that reports issued by VA's Geriatrics and Gerontology Advisory Committee will be submitted simultaneously to the Secretary and the appropriate Congressional committees; to amend section 617 of title 38, United States Code, to raise the limit on Home Improvement Structural Alteration (HISA) grants to $3,300 and $1,200, respectively; to extend by one year the period within which VA research corporations must secure tax exempt status and the "sunset" date for establishment of such corporations; and the measure clarifying that, notwithstanding any other law, the Chief Medical Director has exclusive authority to set standards for, and assure consistent performance of, VA laboratory facilities.

In regard to the draft proposal to establish a pilot program of medical research applicable to clinical care in the areas of mental illness, alcohol and substance abuse, and neurologic, psychiatric, and geriatric rehabilitation, The American Legion endorses the recommendations contained in the final report of the VA Advisory Committee for Health Research Policy, issued in January 1991.

In this report, the Health Research Advisory Council recommended that VA develop new research initiatives on mental illness and substance abuse through establishment of Mental Illness Research, Education and Clinical Care Centers (MIRECCs). This program would be modeled on the highly successful Geriatric Research, Education and Clinical Care Centers (GRECCs), which were established in VA beginning in 1975. The Health Research Advisory Council also recommended the expansion of Rehabilitation Research to include cardiovascular, neurologic, psychiatric, and geriatric research to enhance VA's ability to meet the needs of veterans who require psychosocial or physical rehabilitation.

The American Legion views these research proposals as necessary to deal with the emerging health care priorities in VA and the nation at large, and as a means to improve clinical care in VA medical facilities.

In relation to the measure of the draft bill which would authorize VA to procure medical equipment, title to which would be jointly held with any health care facility which provided VA with at least half the purchase price of that equipment, The American Legion has no objection. We view the measure as encouraging a joint-use agreement in instances where cost to both parties would otherwise be prohibitive, based on the idea of providing the highest standard of care. In our view, this measure provides adequate safeguards to VA against fiscal loss resulting from sharing partners abrogating a specific sharing agreement.

The American Legion supports the draft provision to expand VA's authority to provide child care services by amending section 4209 of title 38, United States Code. Currently under the auspices of the Veterans Canteen Service (VCS), child care centers are a useful recruitment and retention incentive. In our view, this measure will provide sufficient flexibility at the local level to develop appropriate child care services.

Mr. Chairman, we believe the proposal to amend section 5004 of title 38, United States Code, to reduce from $500 to $300 thousand the threshold of what constititutes a major medical facility lease places a severe restriction on current practices. By maintaining at a minimum, the $500 thousand threshold, VA will retain the advantage of having greater flexibility in obtaining annual medical facility leases. Reducing the threshold amount will potentially make the lease process longer and significantly reduce the timeliness of the process. In certain areas of the country, obtaining a satisfactory medical facility lease agreement is difficult enough at the current authorized threshold level, let alone further reducing the authorization amount. We see no major improvement to VA services or operations through enactment of this proposal.

Mr. Chairman, veterans suffering from Post-Traumatic Stress Disorder (PTSD) are provided treatment through a multitude of different programs, depending upon the VA facility from which the individual seeks treatment. Veterans with critical cases of PTSD are provided specialized treatment in one of 20 inpatient PTSD units located throughout VA, some are treated on general psychiatry wards, and other veterans are treated on an outpatient basis through the mental health clinic or through specialized outpatient PTSD clinical teams. As far as we are aware, no empirical evaluation of the effectiveness of the various treatment programs has been accomplished.

We do know that many PTSD inpatient programs maintain admission waiting lists. VA has expanded both inpatient and outpatient PTSD care programs over the past year, however, more specialized services are required. VA's Special PTSD Advisory Committee has recommended increased funding for fiscal year 1992 to expand both inpatient and outpatient PTSD services. The advisory committee has also recognized the unique problems of PTSD cases which are complicated by substance abuse.

The American Legion believes PTSD treatment in VA has long been recognized as unique and appreciates the recommendation of the House Veterans Affairs Committee to provide increased resources in fiscal year 1992 to expand VA's PTSD treatment capability. We support the draft legislation to accomplish this objective. We also support intensified PTSD research initiatives as proposed in the draft legislation and the measure calling on VA to develop a comprehensive strategic plan in the provision of PTSD care.

With regard to the draft proposal to expand the VA's Homeless Chronically Mentally Ill (HCMI) program, The American Legion views this initiative as providing a much needed augmentation to this recently established VA program. According to the third progress report on the HCMI program, published by VA in December 1989, the VA has established 45 HCMI programs in 26 states and the District of Columbia. A companion 'Domiciliary Care for Homeless Veterans' (DCHV) program is operational at 20 VA medical centers. These combined programs represent, to our knowledge, the largest integrated treatment program for the homeless chronically mentally ill in the nation.

The American Legion strongly endorses the proposal to expand this program to new locations which demonstrate the greatest need, and to establish a pilot program emphasizing cost-sharing with a public or private entity for the care of homeless veterans. As this Committee well knows, The American Legion, Department of Pennsylvania, has already established a successful cooperative homeless veterans program with the Pittsburgh - Highland Drive Medical Center. The Department formed a nonprofit-corporation, bought four VA foreclosed properties, and made them available to

7

HCMI patients. VA medical Center - Highland Drive assisted in the renovation work required on the properties. The formerly homeless veterans with chronic psychiatric and/or substance abuse problems, would otherwise have had no place to live after their discharge from VA treatment. Under this cooperative HCMI program, they can continue to receive necessary VA care while engaging in meaningful training or employment activities. Mr. Chairman, we believe the cooperative program in Pittsburgh, PA can be a model for future joint VA and public/private sector initiatives.

Mr. Chairman, in summary, The American Legion believes a need exists to expand certain treatment programs within VA and supports the establishment of new medical initiatives to meet identified veterans health care needs. Our testimony today only applies to a limited number of VA medical care programs.

In addition to supporting the programs addressed in the draft legislation under consideration, The American Legion has a much broader agenda in relation to the VA health care system. We believe resources must be adquate to support a full range of VA health care services. The root underfunding of VA must be corrected to ensure appropriate health care is available to all VA beneficiaries not only those requiring specialized care modalities.

Mr. Chairman, that concludes our statement.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Paul S. Egan
Legislative Director

Before The

House Veterans Affairs Subcommittee on Hospitals and Health Care

On

Draft Health Care Legislation

April 10, 1991

Mr. Chairman and members of the Subcommittee, Vietnam Veterans of America (VVA) appreciates the opportunity to appear and offer comment on the proposed draft health care legislation. There is much to commend this legislation and VVA is generally supportive of many of its provisions. For purposes of this testimony, we will confine our remarks to those provisions within the draft bill that we feel qualified to address. Apart from these remarks, we will offer a few suggestions to further fortify the draft measure.

At the outset, we are compelled to suggest , as a general principle, that the subcommittee refrain from authorizing more in health care than the VA can realistically deliver. From a fiscal standpoint alone, we have witnessed the incremental expansion of VA-authorized health services over the years to the extent that there are insufficient federal resources to accommodate all the services that have been authorized. With too few dollars in the VA health budget chasing too many services already on the books, the availability of service to veterans has all too often become a cruel joke. Our belief in this basic principle has formed the basis of our support for the Secretary's commission to examine the VA's health mission.

A second equally important principle we offer as a preface to today's comments on the draft legislation holds that there is no other VA health care mission more fundamentally significant than the VA's responsibility to assure prompt, courteous and quality care for service disabled veterans. However unfortunate it may be that the Secretary's "mission commission" offers the appearance of unwillingness to subscribe to this principle, the House and Senate Veterans Affairs Committee most certainly should.

In this connection, it can no longer be simply assumed that quality is generally good in VA health care facilities or that well publicized deplorable conditions in facilities such as Cleveland or more recently the North Chicago VA Medical Center are isolated instances. The fact is health care in many of the VA's medical centers is substandard. That being so makes continuing the policy requiring service disabled veterans to be exclusively dependant on VA-provided care untenable. As we have stated over and over again, service disabled veterans should be permitted to choose health providers offering care satisfactory to the veteran at VA expense. To do less is to effectively condemn the service disabled to substandard care which in Cleveland, North Chicago and elsewhere has become outright hazardous to one's health.

Dental Care

The draft legislation would take two steps in the area of dental care; dental care would be authorized to prepare veterans for hospitalization or for veterans receiving VA treatment and would increase to $1000.00 the threshold over which fee-basis treatment would require a second opinion.

The first of these steps is sound. It is difficult to imagine that the VA needs the specific authority granted under the terms of the draft provision in order to provide dental care so obviously and self evidently necessary. Here again, however, the VA has failed all too often to assure continuity of care in treating the veteran as a whole as opposed to treating the veteran as a collection of assorted maladies, some of which are authorized for treatment and some of which are not. That this authority is needed further supports a policy of allowing service disabled veterans to choose the private sector if that is what it takes to secure care that is satisfactory to the veteran.

The second dental provision seems motivated by a concern that fee-basis procedures exceeding $1000.00 in cost might be unnecessary and constitute needless expenditures of scarce VA health resources. We have no quarrel with this fiscal concern, but the heart of this provision should instead be predicated on the more important policy considerations governing the use of second opinions and who should benefit from them.

If it is conceded that the VA is entitled to a second opinion in order to assure the legitimacy of its expenditures on dental care, it must also be conceded that the veteran getting dental care from the VA should be entitled to a second opinion in order to assure that VA's care is appropriate. This same principle should extend to all areas of health care beyond dental care alone. Second opinions in the medical care arena can be used for a variety of purposes, but none is perhaps more important than in assuring the veteran of quality and this is just as important for VA-provided care as it is for fee-basis care rendered in the private sector.

Fee-Basis Care

Another of the draft bill's provisions would authorize fee-basis treatment or contract hospitalization for totally disabling conditions that are service related and permanent in nature. While VVA supports this provision as fully consistent with the preferred policy of choice in the selection of health providers by service disabled veterans, why stop at totally disabling conditions?

As VVA has enunciated many times before, most recently in testimony presented to a joint hearing of the House and Senate Veterans Affairs Committee on February 28, 1991, all service disabled veterans should have the benefit of choice and fee-basis treatment should be reimbursed using the same schedule of rates employed by the Department of Health and Human Services in Administering Medicare programs. Under our proposal, any service disabled veteran rated at 30 percent or more disabled should be eligible for fee-basis care of both service related and non-service related problems. Those rated less than 30 percent disabled should be eligible for fee-basis care of only service related problems.

In offering this suggestion, we are clearly aware of likely opposition in the organized veterans community here in Washington, DC. However, it is nevertheless critically important to open a legitimate dialogue on the topic of how well service disabled veterans are being treated currently by the VA. If the care offered by VA were satisfactory to disabled veterans, our proposal would be for less popular than it is among those veterans we hear from who are forced to use the VA for free care. Similarly, if the quality of care in VA facilities were better, far more disabled veterans would be relying on the VA than currently do. On this latter point it should surprise no one to learn that of all the VA's inpatients, only one third are service disabled veterans and only half of those are being treated for a service related disability.

Under the circumstances, it seems highly unlikely the VA will suffer from lost demand for services even if the entire third of its disabled clients, the very individuals to whom we as a nation owe the most, elected to get care from providers outside of the VA. The burgeoning population of aging veterans whose maladies are unrelated to military service can surely fill any demand for service vacuum created by disabled veterans opting for better quality and more satisfactory medical care in the private sector.

Recruitment and Retention

Two of the provisions of the draft bill are directly aimed at recruiting and retaining qualified health care personnel. Another provision establishing minimum credentials for social workers is indirectly related to recruitment and retention.

The two directly related provisions would require two year obligations on the part of participants in the VA's Health Professional Scholarships program and authorize the Secretary to provide promotional items of nominal value for recruitment purposes. Each of these provisions are well advised and should be useful in giving the VA the flexibility it needs to compete with the private sector for scarce health personnel resources. The third indirectly related provision setting minimum credentials for social workers may not be as well advised.

While the VVA has no quarrel with the setting of minimum credentials for professionals in any health discipline, the unilateral setting of a standard could have serious consequences for recruitment of otherwise competent but uncredentialed professionals. In fact, it should be noted that the drive toward minimum credentialing over the last several years throughout the various medical disciplines has played a contributing role in exacerbating sometimes artificial shortages in health disciplines, particularly some of the more sophisticated allied health disciplines.

As an example we refer the subcommittee to another point raised in our testimony at the February 28, 1991 legislation priorities hearing. Under the heading of "demobilization and transition assistance" we described a veterans hiring program currently operating at a University of Maryland Medical System hospital in Baltimore, Maryland. The experience at this particular hospital in its difficulty recruiting credentialed respiratory therapists has been duplicated in both public and private sector hospitals around the nation. The inability to attract credentialed therapists meant going to considerable expense contracting with temporary personnel agencies. With its new veterans hiring program, individuals with appropriate military training and experience, individuals capable of carrying out basic respiratory treatments under the supervision of a credentialed therapist, are hired on condition they pursue a credential using the hospital's regular tuition reimbursement benefit. The result of this hiring program, apart from its obvious benefit to the veterans hired, has brought about a complete cessation of expenditures for temporary personnel, quality is vastly improved and turnover in the respiratory therapy department is negligible.

The VA could benefit from adopting a program modeled after the one operating in Baltimore. Such a program could also be extended to virtually any medical discipline in which the VA has a shortfall. For the subcommittee's review, a summary of this program is attached.

Clinical Care Research

Other of the draft bill's provisions with which VVA has a keen interest are those requiring, subject to available appropriations, pilot programs of research into clinical care. The specific areas to be researched are mental illness, alcohol and substance abuse, PTSD and neurologic, psychiatric and geriatric rehabilitation. Assuming we are correctly reading the intent of these provisions as designed to better understand what treatment modalities work best with individuals afflicted with each of these problems, we would be hard pressed to be more fully in agreement with the need for this type of research.

For whatever reasons, much of the research conducted by the VA, typically in conjunction with its teaching affiliations, is esoteric in nature, yielding relatively little of value to veterans needing care. Naturally there are the celebrated research breakthroughs in medicine that have derived from VA supported research, but those breakthroughs are the exception rather than the rule and those successes have not been duplicated in the more subjective fields of psychiatry, psychology, substance abuse or PTSD. What research that has been done in these more subjective fields have yielded either improvements in understanding the etiology of pathology or in diagnosing pathology, but have offered little in the realm of what works in treating pathology.

supportive of the multifaceted approach taken under these provisions. Much of the legislative or other efforts undertaken to address the matter of homelessness in the past have been far too limited in scope and typically designed to meet only emergency circumstances. This has brought about needed attention to provision of overnight shelters and soup kitchens. However, with the important exception of the McKinny homeless initiative, too little attention has been given to housing of longer or extended duration in conjunction with badly needed resorative services. The draft bill's emphasis on outreach, medical care and transitional housing represent a well designed combination of services.

Mr. Chairman, this concludes our statement.

University of Maryland Medical System
University of Maryland Hospital

February 20,1991

Tom McCarthy, RRT
Assistant Director
UMMS Respiratory Care
22 S. Greene Street
Baltimore, MD 21201

Paul S. Egan
Legislative Affairs Director
Vietnam Veterans of America
1224 M Street, N. W.
Washington, DC 20005

Dear Mr. Egan:

When we last spoke concerning the further development of the veterans hiring program, I promised to forward profiles of some of the individuals in the program.

The profiles of the two individuals that are attached are representative of the average personnel in the program. The profiles were written by these individuals and, I believe, they shed some light on a few of the problems that veterans are encountering in the job market. Clearly, these profiles indicate that there is a great deal of talent and potential that is not being recognized or utilized. I am hopeful that the success of this program will focus some attention on the talents and potentials of many veterans that continue to go unrecognized in the job market.

Thank you very much for your assistance and input over the last two years.

Sincerely,

Tom McCarthy

Tom McCarthy, RRT

TM/bal

Enclosures

UMMS RESPIRATORY CARE
VETERAN'S HIRING PROGRAM

CONTENTS

I. Program Overview

II. Participant Profiles

III. Program Policy

- Intent
- Eligibility
- Selection Process
- Condition of Employment
- Relocation Assistance
- Tuition Reimbursement
- Employee Benefits

APPENDIX A

California College
Entry Level Respiratory Technician

APPENDIX B

Relocation Assistance

APPENDIX C

Tuition Reimbursement

APPENDIX D

Employee Benefits

PROGRAM OVERVIEW

There is currently an acute shortage of credentialed Respiratory Therapists in the United States. Projections indicate that between now and the year 2000 there will be a 35% increase in demand for Respiratory Therapists. While the career field has traditionally looked to two and four year colleges to supply enough graduates to meet staffing needs, current graduation levels are low and cannot be expected to meet staffing needs now or in the near future.

The Baltimore-Washington corridor is one of the many areas that have been highly impacted by the lack of qualified personnel. Almost every hospital in this area is utilizing contract personnel supplemental staffing mechanisms, many hospitals remain short staffed.

Some area Department Directors have been forced to hire underqualified individuals in order to meet basic operational staffing levels. While the pursuit of this option by these Directors has partially addressed a quantity of staffing issue, quality issues have suffered greatly and have been reflected in the quality of patient care provided. Furthermore, Respiratory Departments that are staffed as such tend to stagnate and ultimately regress relative to the scope and quality of services provided.

One major institution in the area has taken a somewhat more realistic approach to the staffing shortage by recruiting individuals with Bachelor of Science Degrees in Biology or related sciences. These individuals are then trained by the hospital from the basics on to more sophisticated practice. Although this method lends itself to better quality assurance than does using underqualified individuals, it is a very time consuming and expensive approach. The majority of these recruits have never been involved in patient care and they require lengthy training and orientation periods.

By contrast, from 1988-1990 Capitol Hill Hospital's Respiratory Care Department did not place an employment ad, did not utilize any agency personnel, maintained a full staffing complement of qualified and upwardly mobile individuals, and observed a marked increase in the quality of patient care provided. Higher levels of staff performance and a broader inventory of abilities made it possible for the Department to expand into areas of patient care that were of great benefit to the community. The stability and quality of the staff enabled the Department to become a truly dynamic provider of top quality patient care.

The key to that success and stability was a willingness on the part of management to recognize and acknowledge the qualifications of veterans of the Armed Forces.

In 1988 the Department implemented a program whereby veterans who had acquired the appropriate medical training in the service were screened and interviewed for jobs as General Care Technicians. The program was designed so that these individuals would be able to utilize their knowledge and training to secure reasonable employment opportunities and also provide them with an educational opportunity to earn a credential in the field of Respiratory Care. As well as providing the hospital with well trained and experienced individuals, the program also offered the veteran a very attractive transitional bridge back into the civilian world.

One of the prime considerations of the program's development was that it was geared towards helping veterans succeed by building on the abilities and talents they had acquired in the service. In many instances veterans find themselves in a situation where talents, abilities, and education gained while serving their country goes unrecognized in deference to a number of educationally chauvinistic civilian organizations. These vets usually transition from positions of high responsibility and function in the military to minimum wage positions in the civilian world. The health care industry is an area where this happens with a great deal of regularity. The program at Capitol Hill Hospital was designed to focus on talent and ability.

In September of 1990, Capitol Hill Hospital announced that its focus would change from that of an acute care facility to one of a skilled nursing facility with a large psychiatric component. There would be little or no need in their structure for Respiratory Care services. Capitol Hill Hospital is a Medlantic Corporation affiliate and other Medlantic affiliates, although short staffed for Respiratory Care Practitioners, expressed an unwillingness to hire any of the veterans in the program.

In October of 1990, University of Maryland Medical Systems (UMMS) announced that they would be restructuring their Respiratory Care Services. Administration at UMMS reviewed the Veterans Program, interviewed individuals enrolled in it, and extended job offers to each and every individual in the program. Robert Adams, Vice President of Operations and Rob Mekelburg, Director of Operations were enthusiastic advocates for the program and were instrumental in having the program adopted and implemented within the corporate structure. The program is now fully integrated into the structure of the Respiratory Care Department and is enjoying continued success in its new setting. Presently, 50% of the clinical staff is comprised of veterans and efforts to recruit qualified veterans are ongoing.

A typical candidate might be a USAF 90250 (Medical Service Specialist) or a 90450 (Cardio-Pulmonary Specialist). After a review of the candidate's educational records, scope of experience, and APR's (Airman Performance Reports) a decision would be made to offer the candidate the job with the stipulation that he or she enroll in an American Medical Association approved school and achieve a credential in Respiratory care within eighteen months.

The starting base salary for individuals entering the program is $23,000.00 per annum, exclusive of evening and weekend differentials. Full benefits include health and dental coverage, tuition reimbursement, disability coverage, and a retirement program. Once an individual has achieved a credential as a Certified Respiratory Care Technician the base salary increases to $27,000.00 per annum and should the individual achieve the next highest credential of a Registered Respiratory Therapist, the base salary increases to $29,120.00 per annum.

The individuals in the program are given practical experience to complement their coursework in school and as their knowledge base increases the scope of their duties and responsibilities increases accordingly. Many of these individuals have been qualified to work with patients on mechanical life support systems in an Intensive Care setting within a year of their introduction into the program.

The Administrative section of the UMMS has invested a great deal in the furtherance of this program. The return on that investment has certainly been spectacular and has given the phrase "Hire the Vet" a place in the handbook of managerial wisdom. There is no question as to these individuals' ability to function in a clinical setting and deliver quality patient care. The added bonuses from a managerial perspective are that these individuals are disciplined, self motivated, willing to assume responsibility, are team players, and possess "can do" attitudes.

I am hopeful that the success of this program will prompt other organizations to follow suit and offer veterans the opportunity to utilize the skills they acquired while serving their country.

Danny Durost
USAF 90250

In June of 1990 I was told by friends that there were job openings in Respiratory Therapy, at Lock Haven Hospital, the operating room for an O.R. tech position, and openings in the laboratory for lab techs. When I went for my interview I was told the only position available was in Central Sterile Supply. The job was part-time at minimum wage with no benefits. I asked about the other jobs mentioned above and I was told they weren't available. I asked if they became available, could I move and I was told yes as long as I bid on the job. I started in Central Sterile Supply in July of 1990. My first day on the job I ate lunch with an anesthesiologist who told me the O.R. tech slot had been open for some time. Then I talked to the director of respiratory therapy. She told me they had four slots available. She looked over my resume and wanted to hire me right then and there. Nurses from the floor saw my resume and they wanted me. The nurses fought for me but lost to the upper management stating that they couldn't accept my military certification and that the military didn't do me any favors by giving them to me. The chief nurse of the O.R. said the same thing to me when I wanted the O.R. tech slot. Finally the Director of Respiratory and myself talked to the Vice President of the hospital. He said he would talk to the president and see what he thought I should do. A week later we got together (the Vice President and myself) and he said because of the union and union rules I would have to quit and be rehired. If I didn't do that I would have to stay in Central Sterile Supply for one year before I could move. The Vice President told me he already talked to Respiratory and they knew what to do. I talked to them and they said fill out an application, then give a two week notice. I was told to date the application two days after I quit. I did so. The Director of Respiratory told me I was getting full time with benefits and a raise. After I quit, at the advice of Respiratory and the Vice President, nothing happened after a month and a half. I was told they were having budget problems. I kept getting the run-around so I gave up.

I had eight years experience in the U.S. Air Force. I worked Aero-Vac, surgery, primary care, and emergency room. I find it hard to believe I couldn't have been used somewhere else in that hospital other than Central Sterile Supply.

In December of 1990 a friend told me that the Respiratory Care Department at University of Maryland Hospital was hiring ex-military medical people who met certain criteria. I applied and interviewed with Tom. I am now employed at a livable wage, have health benefits, and will be enrolling in the California College to earn a credential in Respiratory Therapy.

Bill Hunter

USAF 90250

I was discharged from active duty Air Force on 28th of March 1988. After working as a 90250 medical technician in an ICU setting for the past three years. On April 2nd 1988 I was employed by Capitol Hill Hospital as a med tech in their 12 bed ICU. My duties were as follows: monitoring patient's cardiac arrhythmias and doing general nursing duties such as stocking supplies, ordering supplies, checking emergency crash cart equipment, assisting physicians and inserting arterial lines and swan gantz lines. Also assisted nurses with changing beds, emptying bed pans, and cleaning equipment, as well as escorting patients out of the ICU to the general floors when discharged from the unit. There were no good prospects for advancement, financial or professional, in this position.

After six months in this setting I got word that Tom McCarthy RRT, Director of Respiratory Therapy Department was recruiting for general care technicians in the Respiratory Care Department. Tom was specifically looking for individuals with military training.

I was hired as a general care tech with the agreement that I would pursue my credentials in the field. After getting my feet on the ground in Respiratory, I enrolled into the California College of Health Sciences Respiratory technician course. After 16 months of study and the opportunity to work in the ICU on my own as a GJT, I graduated from the course and will be sitting for the CRTT Boards in March.

UMMS RESPIRATORY CARE VETERAN'S HIRING PROGRAM

Intent:

It is the intent of this program to provide employment and upward mobility opportunities in the field of Respiratory Care for qualified veterans of the Armed Forces who meet eligibility standards and selection criteria as defined by UMMS.

Eligibility:

Veterans of the Armed Forces who served as Medical Specialists or Cardio-Pulmonary Specialists and whose training records indicate education and experience in Respiratory Care during the time of their enlistment. Veterans with the following military qualifications are eligible to apply:

USAF	USA	USN
90250	91 BRAVO	8541
90450	91 CHARLIE	
	91 VICTOR	

Applicants must also have been honorably discharged from the armed forces to be eligible.

Selection Process:

The selection process shall include screening for the following documents and criteria;

1. DD214 to determine MOS and type of discharge
2. Copies of training records to validate training in areas of Respiratory Care
3. Copies of performance reports that indicate the individuals ability to deliver high caliber patient care
4. Copies of certificates or diplomas from Armed Services schools.

Condition of Employment

Upon being offered employment in respiratory care at UMMS, the individual upon accepting employment agrees to enroll, within six months of their date of hire, in either:

1. A traditional two or four year college level degree in respiratory therapy.

2. Or non-traditional certification course to be completed within the time frame stipulated by the institution offering the course (Appendix A).

Relocation Assistance

Relocation assistance is available as defied in the Employee Relocation Allowance Policy (Appendix B).

Tuition Reimbursement

Tuition reimbursement is available as defined in the Tuition Reimbursement Policy (Appendix C).

Employee Benefits

A summary of employee benefits is contained in Appendix "D".

STATEMENT OF
CLIFTON DUPREE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
"VETERANS' HEALTH CARE AND RESEARCH AMENDMENTS ACT OF 1991"
APRIL 10, 1991

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I want to thank you for inviting us to testify today. We are grateful for the opportunity to express our views on the various provisions, provided to us in draft form, set forth in your legislation, the "Veterans' Health Care and Research Amendments Act of 1991".

These provisions address several critically important areas within VA's health care programs - research and clinical care, PTSD and homeless programs, home improvement and structural alteration grants, and cost sharing for the procurement of medical equipment among others. The members of our organization have a keen interest in VA's ability to deliver these programs in a cost-effective and high quality manner. Directly or indirectly, such issues as cost sharing, VA's Congressional reporting mechanisms, child care and improved working conditions at VA facilities all ultimately affect VA's ability to provide quality "hands-on" patient care. We look forward to the eventual improvement of all the programs addressed in your legislation.

VA Home Improvement and Structural Alteration (HISA) Grant

PVA is extremely grateful for the inclusion of this provision in your bill.

As you know, increasing the HISA grant for our members and other eligible veterans has been a top priority for PVA for several years. Your proposal would amend VA's Home Improvements and Structural Alterations (HISA) grant program to partially offset the increase in costs for structural home modifications since 1976 when the issue was last addressed.

As you know, VA is authorized to provide one-time grants to help pay for necessary alterations to the homes of certain very seriously disabled veterans to assure continuation of treatment for the veteran's disability or to provide access to the home or to essential lavatory and sanitary facilities.

In 1976, Public Law 94-581 created two categories of HISA grants: one with a cost ceiling of $600 for structural home modifications of a minor nature in connection with the treatment of nonservice-connected veterans; and one with a cost ceiling of $2500 for more extensive structural home modifications in connection with service-connected veterans.

While the costs associated with home modifications have more than doubled over the past 14 years, the limitations on HISA grant amounts have not been increased since 1976. This fact has seriously eroded the ability of severely disabled veterans to make necessary adaptions to their homes and apartments to accommodate wheelchairs, dialysis equipment, and other essential apparatus. Equipment such as ramps and the installation of air-conditioning or winterizing insulation in order to provide consistent temperature control for the neurological consequences of spinal cord injury, represent just a few examples of the special needs - and expensive alterations and equipment - associated with severe disabilities.

We appreciate your recommendation to increase the HISA grant from $2500 to $3300 for service-connected veterans and $600 to $1200 for nonservice-connected veterans. We continue to believe, however, that the enactment of a cost ceiling of $5000 for service-connected veterans (in addition to the $1200 limit for NSC veterans) would provide a more equitable level of real assistance equivalent to that provided by Public Law 94-581.

The amount of money a severely disabled veteran must spend on home modifications is generally far in excess of that provided by HISA. Even coupled with the specially adapted housing grant provided by Chapter 21 of title 38, USC, out-of-pocket expenses to accommodate a variety of problems associated with wheelchair accessibility and neurological consequences are significant. Certainly, an individual who must move from a specially adapted house to another house will experience significant costs. This is especially true since the "cost of accessibility" does not generally add to the value of a house and is not generally recouped when the house is sold.

The purchase price of a straight stairway lift alone has risen from $1570 in 1976 to $3860 in 1990 - a curved lift generally costs in excess of $7000. Carpenters' fees have risen dramatically as well, more than doubling since 1976. The construction of a small ramp and a widened doorway will easily require the expenditure of several thousand dollars.

The Congressional Budget Office has estimated the enactment of $5000 and $1200 cost ceilings for service-connected veterans and nonservice-connected veterans respectively, would entail costs of only $2 million in both budget authority and outlays in FY 1991.

As you know, the HISA provision setting $5000 and $1200 limits has been incorporated in S. 127, introduced this Session, and has been strongly recommended by the authors of the FY 1992 Independent Budget as well as the many organizations which endorsed that document.

Certainly, PVA understands the restraints imposed by reconciliation provisions on new legislative initiatives. In view of the very low cost of the HISA grant provision, the strong VSO support for such improvements, and the significant benefit such an initiative would provide for seriously disabled veterans, we firmly believe this important legislation can be equitably enacted within the framework of the Budget Reconciliation Act. We will work with you in any way we can to ensure that this is done.

Philippines Health Care Contract Authority

Contract Authority (Section 632(a), title 38, USC):

PVA supports this provision which would extend through September 30, 1992, VA's authority to enter into contracts with the Veterans Memorial Medical Center to provide hospital care and medical services for eligible veterans in the Republic of the Philippines.

Medical Research to Improve Clinical Care

PVA is pleased to support the provision in your bill which would establish a pilot program of medical research to improve the provision of clinical care in VA facilities. Your bill calls for the Secretary to solicit proposals from VA Medical Centers for the conduct of research applicable to clinical care in the areas of (1) mental illness, (2) substance and alcohol abuse, and (3) neurologic, psychiatric, and geriatric rehabilitation.

Mr. Chairman, this proposed legislation falls in line with provisions in Title 38, USC., which specify that VA support studies in the several identified areas -- one of which is spinal cord injury. For the members of PVA, VA's Medical and Prosthetics Research account represents a critically important investment of government funds. The additional funding proposed in your bill to fund grants for cooperative research projects could be extremely beneficial for patients of the VAMC's receiving these awards. Ultimately, we would hope such a program could benefit the entire VAMC system. Since VA research is clinically oriented and directly concerned with VA patient's needs, any enhancements to the program should have a direct positive effect for our members and all disabled veterans.

As stated in the Independent Budget, opportunities to pursue answers to medical problems have never been greater, especially in molecular biomedicine. The techniques of this subspecialty are particularly applicable to research in trauma and diseases of the brain and spinal cord.

Certainly, we are extremely pleased that you have included research applicable to clinical care in the area of neurology.

Breakthroughs in the field of spinal cord regeneration are on the horizon. Of course, PVA would like to see more money invested in research. Whether as the result of military service, or through accidents, this year thousands of Americans will suffer a spinal cord injury resulting in lifelong paralysis. Thousands of others will suffer from a spinal cord disease, stroke or traumatic head injury.

VA research constitutes one of the Department's most distinguished chapters. Hundreds of thousands of disabled Americans - veterans and nonveterans - have benefitted from VA researchers' contributions to medical knowledge. PVA appreciates the additional funding which this Subcommittee recommended to the Budget Committee and we encourage you to continue to authorize improvements in research programs. We will do everything we can to ensure such improvements become a reality.

Regarding the provision in your bill which would extend the time period within which VA research corporations must secure tax exempt status, PVA believes these corporations set up by government institutions can be very useful for facilitating and encouraging medical research. We are pleased to support the extension of this authority.

Major Medical Projects and Major Medical Facility Leases

This provision would amend section 5004, title 38, USC., to make clear that funds may not be appropriated or expended for any major medical project or major medical facility lease unless funds for such a project have been specifically authorized. This provision appears to support existing language in section 5004. PVA has no objection to its enactment.

PVA also has no objection to your provision which would reduce from $500,000 to $300,000 the threshold for what constitutes a major medical facility lease. We believe this provision would help to ensure that scarce funds will be utilized in the most cost effective manner.

Fee-Basis Treatment and Contract Hospitalization

PVA is pleased to support this provision which would authorize fee-basis treatment or contract hospitalization for any disability of a veteran who has a permanent and total service-connected disability or disabilities. As you know, VA provided authorized non-VA hospital care for the nonservice-connected disabilities of

such veterans between 1972 and 1986. When PL 99-272 was implemented in 1986, VA discontinued this practice.
We support your legislation which would restore the pre-1986 authorization to cover these situations in cases where VA is unable to furnish economical hospital care or medical services.

Extension of Annual Reporting Requirement on Furnishing Nonservice-connected Health Care

PVA supports the extension of this reporting requirement originally enacted by PL 99-272 in 1986. These reports contain considerable information about the numbers and characteristics of veterans who are eligible for VA health care under PL 99-272, and provide important data which is fundamental for the Congress to make decisions regarding the operation of VA's medical care system.

Procurement of Medical Equipment

PVA supports this provision which would authorize VA to purchase medical equipment to be shared jointly with another health care facility. Your bill requires that the other facility provide VA with at least half the purchase price of the shared equipment.

Mr. Chairman, in view of VA's tremendous equipment backlog, we believe such sharing agreements must play a major role in addressing the issue of existing outmoded and inefficient VA medical equipment. More and more of this equipment is reaching the end of its useful life while medical technology, including diagnostic and treatment equipment, continues to advance. Sharing sophisticated equipment with expensive price tags between several health care facilities appears to represent a cost-effective approach to the delivery of care and the budgetary problems associated with the present state-of-affairs in VA.

Post Traumatic Stress Disorder (PTSD)

As a result of the significant unmet needs which exist in VA's PTSD treatment program, PVA is pleased to support legislation which expands or improves the services VA provides to veterans suffering from PTSD. We continue to be deeply concerned about the well-being of individuals who must rely on the mental health services of the Department of Veterans Affairs.

The statistics alone are overwhelming when one considers the vast numbers of veterans who currently suffer from PTSD.

Further, since PTSD is thought to be chronic rather than acute, the lifetime prevalence of the disorder necessitates, in our opinion, the expansion of existing programs as well as the creation of additional ones to augment VA's current efforts to provide care for veterans suffering from PTSD. With the number of new PTSD patients exceeding 80,000 per year, we do not see how such improvements can be avoided. There is simply too much at stake in terms of the relationships between PTSD and drug abuse, incarceration, other psychiatric disorders, family problems, and a host of other potentially adverse readjustment complications.
The unmet need has clearly been shown to exist and demands better programs to provide quality care.

Mr. Chairman, PVA strongly supports your efforts to expand the Specialized Inpatient PTSD Unit (SIPU) program. Your bill would provide authorization for not less than five new SIPU's for each year during the next five fiscal years, subject to the availability of appropriations.

As you know, the Independent Budget has recommended twenty new PTSD Clinical Teams (PCT's) in FY 1992 to supplement the existing 44 teams presently in the system. Your bill provides for ten additional PCT teams to be established during the next year. We believe the establishment of these PCT's will go a long way in addressing the unmet need for PTSD treatment.

We are also pleased to support the provision in your bill which authorizes the Secretary to conduct a pilot program to contract for care, treatment, and rehabilitative services in halfway houses, therapeutic communities, and other community based treatment facilities. Much can be gained from such contracts including the involvement of both public and private sector groups in the provision of training and employment opportunities for veterans who have received successful treatment under this program.

Finally, we endorse the remaining provisions in your bill which address the PTSD issue such as, scholarship and tuition reimbursement programs, PTSD research programs, and the necessary reporting requirements which must accompany them, have PVA's strong support.

OUTPATIENT DENTAL CARE

This provision has as its major objective the improvement of VA health care. To achieve this objective, the Committee proposes to extend outpatient dental care to certain eligible veterans just as outpatient medical care is provided to certain eligible veterans. While this proposal extends eligibility for outpatient dental care -- at a cost saving to the Department -- the original need for outpatient care for all "Category A" (mandatory) veterans remains.

Continued under-funding is eroding the ability of the VA health care system to provide entitled needy veterans access to appropriate services. At the same time, this problem is compounded by ambiguities in health care entitlement allowing medical care administrators the opportunity to ration care or redirect care when resources are not available. As a result, veterans in need of medical care simply are not receiving the care they need. This problem arises primarily in the provision of outpatient and nursing home care for veterans with "Category A" (mandatory) entitlement.

While PVA supports this proposal, we strongly believe that making a clear definition of health care entitlement for all "Category A" veterans will ensure that those veterans who require treatment will receive the full range of services needed in the most cost-effective manner.

Fee-Basis Dental Care

PVA has no objection to this provision which would increase, from $500 to $1000, the dollar limit required for a second opinion exam.

Health Professional Scholarship Program

Mr. Chairman, PVA appreciates your efforts to improve recruitment and retention of nurses within the Health Services and Research Administration (VHSRA). VA's ability to recruit and retain qualified health care professionals directly affects the quality of health care provided to our nation's veterans.

As you know, the Health Professionals Scholarship Program (HPSP) was authorized by Public Law 96-330, in August 1980. It is a competitive federal grant program established to assist the Department in recruiting and retaining a pool of career-oriented nurses as well as other health professionals. Students enrolled in a full-time course of study in nursing or other health disciplines, such as physical therapy, may apply for funds. Recipients of such funds currently incur an obligation for service to VA for a period of one year for each year which funds were provided.

In fiscal year 1990, VA awarded a total of 439 scholarships to students furthering their education in the field of nursing while 83 scholarships were awarded to students pursing education in other allied health disciplines. VA's fiscal year 1992 appropriation request, for this program, totals $10,113,000 which is estimated to fund approximately 564 new grants.

While extending the service obligation from one to two years for participants in the HPSP may assist VA in retention of health care professionals, its effect on recruitment must also be considered. In order to recruit and retain professionals with these scholarship funds, the terms of service obligation must remain consistent with other federal grant programs.

For example, the U.S. Public Health Service manages several scholarship programs for students enrolled in schools of nursing. In the undergraduate scholarship program a two-year service obligation is currently required of all recipients.

Your proposal to increase VA's service obligation from one year to two in the HPSP, appears to be consistent with other federal scholarship programs targeting the same pool of applicants.

Once again, PVA supports this provision and believes it will serve as a positive tool not only in VA's recruitment and retention efforts but in VA's ability to provide quality medical care to our nation's veterans.

Promotional Items

Also related to VA's continuing efforts to recruit health professionals is the proposal to authorize VA to provide promotional items of a nominal value. As you know, the pool of health professionals from which VA is attempting to recruit is limited while competition is fierce. PVA supports this provision in a effort to improve VA's recruitment capability.

Geriatrics and Gerontology Advisory Committee

Mr. Chairman, PVA continues to be concerned about the Department's short and long-range planning with respect to the rapidly growing number of elderly veterans. This provision would require that reports issued by VA's Geriatrics and Gerontology Advisory Committee be simultaneously submitted to the Secretary and the Congress. We appreciate your efforts to meet the needs of aging veterans and are pleased to support this provision.

Beginning in the 1980's, most veterans of the World War II and Korean War era -- the largest groups of veterans -- turned 65. In 1980, there were three million veterans age 65 or older and in 1990 this figure reached seven million. By the mid-1990's one-third of all veterans will be older than 65 and by the year 2000, almost nine million veterans will have reached this age.

As people age -- particularly as they age beyond 65 -- they require progressively more health care. Their need for long-term care grows more rapidly than their need for acute care. Statistics on veterans' actual use of VA facilities illustrates this point. Veterans ages 65 to 74 use VA hospital care twice as often as those younger than age 55. Those older than 75 use this care 75 percent more frequently than those in the 55 to 64 age group.

Although this increase in use of VA inpatient care with advancing age is dramatic, it is small compared to the increased use of nursing home care. Men ages 85 and older use VA nursing home care almost 30 times as often as men ages 55 to 64.

PVA believes the necessity of meeting aging veterans' rapidly growing and changing needs is fundamental. As the number of aging veterans grows, the recommendations of the Geriatrics and Gerontology Advisory become all the more significant.

Licensure of Social Workers

PVA is pleased to support this proposal to strengthen standards of practice for social workers within the Department. Your provision would require that social workers employed in the Veterans Health Services and Research Administration (VHSRA) hold a master's degree in social work and, if the law of the States of employment so require, be licensed, certified, or registered.

As you know, the mission of the Department of Veterans Affairs is to provide quality health care to our nation's veterans. This mission includes quality services provided by social workers. In order to maintain high quality care, the standards of care for social workers must be appropriately defined and upgraded.

EXEMPTION FROM THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

This provision would clarify, notwithstanding any other law, the Chief Medical Director has the exclusive authority to set standards for and assure consistent performance of VA laboratory facilities.

Mr. Chairman, quality of care in the VA system is of primary concern to PVA. We expect VA to provide the best in quality of care and, further, to demonstrate national leadership in many areas, including laboratory services and safety.

In an effort to assure public safety, Public Law 100-578, the "Clinical Laboratory Improvement Amendments of 1988," (CLIA) was established. This legislation required the Department of Health and Human Services to set performance and quality standards for all federal and/or private laboratories. As a result, the Health Care Financing Administration (HCFA), in May 1990 and again just recently, published proposed regulations for implementation of this law.

According to the proposed regulations, VA would be required to increase laboratory staffing levels and qualifications, increase monitoring of quality, as well as be subject to random inspections -- at a cost VA estimates to be $72 million. VA would be required to pay $1.2 million to HCFA in certification fees. VA anticipates CLIA will have the largest impact in the area of personnel costs, especially with VA laboratories operating with a 25 percent vacancy rate for medical technologists.

However, the financial burden alone should not be the determining factor on whether to exempt VA from CLIA standards.

If the Congress has mandated that laboratory services across the nation comply with certain operating standards, certainly VA, the nation's largest health care provider, should be required to meet these same standards **or equivalent performance criteria.**

If the latter is the case, VA should be required to document that their existing standards are satisfactory or equivalent in every way. Cost of meeting quality assessment in any aspect of the provision of health care should not be the primary reason to exempt the VA system from national quality standards. If VA is deficient in any way, the Administration and the Congress should insist that VA have all the resources it needs to meet the proper standards and to provided quality of care second to none.

Mr. Chairman, PVA believes the goal of improving the effectiveness of clinical laboratories is laudable. Should VA not be required to comply with these standards, or proven equivalent standards, quality in the VA system would be perceived by veterans, their advocates, and members of the health professions as inferior when compared to the level of care provided in the private sector. The effect this exemption would have on VA's ability to conduct joint research projects with entities who would not be exempt from CLIA must also be considered.

Child Care Centers

Due to VA's need to recruit and retain qualified health care professionals, PVA supports this provision to expand VA's authority to provide child care services by permitting the operation of such centers under the auspices of Veteran Canteen Service (VCS) as well as other appropriate offices of the Department or through contractual arrangements.

In 1987, with the enactment of Public Law 100-322, VA was granted the authority to establish and maintain child care centers. Until this time, child care centers in VA facilities were established through contract/lease agreements or sharing agreements. These centers, however, remained exempt from state regulation while located on federal property.

As you recall, Public Law 100-322 provided VA with the authority to establish child care centers operated under the auspices of the Veterans Canteen Service. While VA was provided the authority to develop child care programs, VCS also became responsible for the cost of renovation, custodial services and utilities of these centers. As a result, Veterans Canteen Service had only one child care program operational by the end of 1990.

Establishment of child care centers at VA facilities is a nonsalary benefit which can be effectively used as a recruitment and retention tool for personnel. Such programs serve to increase the supply of potential employees by bringing into the work force those individuals not currently employed, as well as encouraging existing employees to maintain their affiliation with VA.

Homeless Veterans

As proposed by this legislation, subject to new appropriations, a pilot program would be established to address the unmet needs of homeless veterans. A joint venture between VA and public or private entities, this pilot program would provide outreach to veterans via transportation as well as provide medical care and transitional housing. PVA is pleased to support this provision which would provided necessary services to homeless veterans.

Homelessness is a national crisis which has had a devastating effect on the veteran population. Experts estimate that about one-third of the homeless are veterans -- mostly Vietnam era servicemen. As the vast homeless population appears to be increasing, VA continues to address veteran homelessness via two programs.

The Homeless Chronically Mentally Ill (HCMI) program was established in 1987. This program is intended to provide aid to veterans who need psychiatric and medical care through community-provided rehabilitative services. The Domiciliary Care for Homeless Veterans (DCHV) program offers treatment, in a residual setting, of problems which have led to each individual's homelessness.

The needs for both of these programs are great. In its strategic planning projections for fiscal years 1990-1994, VA estimates that the number of homeless veterans could be as high as 250,000. Eighty-six percent of these individuals are believed to have had some form of psychiatric disorder and a great many also demonstrate medical problems. VA indicates that it had contact with up to 40,000 veterans through these two programs. Between May 1987 and May 1989, 19,687 veterans were assessed by the HCMI program. About 18,000 veterans had participated in the domiciliary care program. Veterans' needs, however, continue to go unmet. This provision needs to be authorized and adequately funded.

That concludes my testimony. I will be pleased to answer any questions.

AMERICAN
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STATEMENT OF THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

SUBMITTED FOR THE RECORD TO THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES

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ON
DRAFT LEGISLATION
VETERANS' HEALTH CARE AND RESEARCH AMENDMENTS OF 1991

APRIL 10, 1991

The American Association of Dental Schools (AADS) represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. We are the only national organization concerned exclusively with the needs of dental education.

AADS is pleased to have the opportunity to submit this statement expressing our views on the draft legislation on Veterans' Health Care and Research Amendments of 1991.

We will focus our statement on two areas of interest to dental education.

Dental Outpatient Reform Initiatives

We applaud the subcommittee for considering draft legislation that includes necessary reforms in this area. Most importantly, the provision would authorize medically necessary outpatient dental care, currently available only on an inpatient basis. AADS has recommended passage of this proposal for several years. The proposal will enhance oral health care and save money, and is supported by the Administration and all major veterans service organizations. It would be an important part of these VA health care amendments.

This provision would change the current eligibility that allows treatment of adjunct dental care problems of inpatients, but precludes the provision of the same services on an outpatients basis -- even though the attending physician determines that the treatment of oral health conditions is necessary to assure successful treatment of the overall medical condition. The requirement that dental care be provided on an inpatient basis is not only costlier for the federal government, but also more inconvenient for patients, and provides a poor teaching model for dental students and residents.

The provision would allow outpatient dental care where "medically necessary in preparation for hospital admission or for a veteran otherwise receiving care or services under this chapter." This would allow limited dental care to veterans to prepare a patient for surgery and other procedures that could be compromised by oral infections; and would authorize medically necessary outpatient dental care to veterans currently active in a VA treatment program

In previous testimony we have noted a number of situations where this change will enhance oral health care of veterans via outpatient care, including alleviating oral complications from cancer treatments, treating oral infections in HIV patients, and addressing oral health care needs prior to treatments for cardiovascular disorders, advanced liver diseases, joint prostheses, end stage renal disease, and pulmonary disease.

AADS also fully supports the draft legislation proposal to modify second opinion dental requirements by increasing from $500 to $1000 the amount that a fee basis dentist can charge without the patient obtaining a second VA examination. This recognizes inflationary changes and helps to promote more efficient VA health care.

Pilot Program for Medical Research

The draft legislation proposes a pilot program of research to improve clinical care. Proposals would come from VA medical centers for research in areas of mental illness, alcohol and substance abuse, and neurologic, psychiatric, and geriatric rehabilitation. To be eligible, a medical center must have entered into an agreement with a medical school or other institution described in section 4101 (b) under which that entity agrees to provide partial funding or in-kind support for the research. It would authorize the program only if appropriations for fiscal year (FY) 1992 are at least $43 million above the President's request, and then $15 million and $30 million above the FY 1992 funding level for following two fiscal years. This program would authorized at $6 million for fiscal years 92, 93, 94.

The draft legislation is an improvement over special medical center research proposals introduced in the 101st Congress and in the current Congress, which are restrictive. They contain no provision for considering research in conjunction with other affiliated health professions schools, such as dentistry, and no authority for participation of private institutions that might present competitive research proposals.

By providing that a VA medical center can qualify for participation by having an affiliation with a medical school or other entity described is § 4101 (b) of Title 38, maximum flexibility would be provided for eligibility of medical centers that can contribute productive research. Among institutions listed in this section are schools of dentistry, and other allied health professions. We are supportive of this inclusion, since all dental schools are affiliated with at least one VA medical center, and approximately 20 to 30% of VA facilities have an affiliation with an allied dental education program. Such facilities have the potential to develop research proposals in areas such as geriatric dentistry.

We do have several concerns about the legislation as currently proposed. Our suggestions are as follows:

> * Funding priority should be given to medical centers that propose interdisciplinary projects in cooperation with a number of affiliated health professions institutions. This will help to stimulate research support and effort from all affiliated education institutions.
>
> * The research scope should be broadened. While the areas listed are certainly important, other types of vital research should not be precluded. For example, it should be clear that substance abuse research includes the overall health impacts of such abuse. The geriatric area should be broader than just rehabilitation, and should refer to improving the health of the elderly and managing the assorted health complications related to aging.
>
> * All types of health research relevant to veterans health care should remain a possibility for these projects; the Department should be allowed to determine which research areas are of pressing concern to the veteran patient population and give priority to those areas. Over time, priorities would change in accordance with the Department's determination of need. The restrictive list should be eliminated.

We urge that the final bill incorporate these suggestions.

Thank you for the opportunity to present this statement for the record.

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Statement of

Nurses Organization of Veterans Affairs

NOVA

By

Noreen Sommer, RN, MSN
President

Before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

Draft Health Care Program Improvements

April 10, 1991

Mr. Chairman and Members of the Subcommittee, The Nurses Organization of Veterans Affairs (NOVA), thanks you for holding this hearing on so many issues of importance to the health care of veterans and the VA system that provides this care. As an organization of VA registered nurses committed to providing quality care to veteran patients, NOVA is keenly interested in issues that affect the ability of the VA to recruit and retain sufficient numbers of qualified nurses and other personnel to provide the care needed. NOVA is supportive of initiatives that ensure the quality of care given to veterans and enhance the quality of life for veteran patients. It is in this context that NOVA wishes to offer our comments on a number of provisions in the draft legislation before us today.

HISA Grants

NOVA supports raising the limit on the Home Improvement Structural Alteration grants. These funds are used by patients to make home improvements; such as building ramps, widening doors and making bathroom modifications. These improvements or modifications often make a considerable contribution to veteran patients who use wheelchairs by increasing mobility, independence and making the home a safer place. These modifications also protect family care-givers from the unsafe practice of lifting the wheelchair up stairs. The costs of these modifications have increased and NOVA supports the continuation of this valuable service and the increase grant recommended.

Laboratory Performance Standards

NOVA recommends careful examination of any provision that might set a standard for VA services that is lower than the community standard of practice. Laboratory services are crucial to the care and treatment of veterans and life and death treatment decisions are made based on clinical laboratory information. As VA strives for excellence in quality, we must not appear to set a standard that is less than excellent.

Child Care Services

NOVA has previously expressed the belief that the availability of child care services at VA medical centers is important in recruiting and retaining qualified health care personnel. The availability of employersubsidized, child care facilities is becoming one of the most popular employee benefits. Women currently make up 80 percent of the workforce in hospitals, making child care a crucial issue.

Some of the VA medical centers have formed a variety of cooperative relationships with other community groups and have done considerable fundraising to keep going or to offer sliding scale fees to employees with lower wages. In some medical centers, many nurses and LVN's have not been able to use the service because the cost was too high or the hours of operation did not accommodate the mandatory shift rotation required of nursing personnel. The overall impression was that the centers provided convenient, good care and were viewed positively as a service to employees and, in some instances, to the community. Also, the child care center was considered a positive factor in recruitment and retention. The measures under consideration today will do much to ease the financial burden currently imposed on the Veterans Canteen Service to provide Child Care Centers and Services.

The authorization for priority enrollment and preferential rates to VA employees according to the need of each priority group will accommodate many nurses, LVNs and nursing assistants who otherwise might not be able to use them. Giving priority to nursing personnel required to rotate shifts by extending hours of operation around the clock will be a positive factor in recruitment and retention. Enabling medical center directors to proceed out of operating funds, and with the authority to construct alter or even lease space in any VA facility, will finally enable the VA to operate Child Care Centers.

VA Health Professional Scholarship

NOVA strongly endorses the VA's commitment to the VA Health Professional Scholarship program, the purpose being to assist in providing an adequate supply of specified health care professionals for the VA and the nation.

The scholarship program is highly successful in recruiting nurses for the VA, and is expected to help retain them. The benefits of the program are generous; paying a monthly stipend, tuition, fees, and some educational expenses such as books and necessary equipment, while asking little in return. In some schools, tuition alone can cost over $18,000 for one year (12 months). For the 1990-91 academic year, the VA received over 1500 nursing applications from students at NLN (National League for Nursing) accredited colleges and universities and awarded 439 scholarships to nursing students enrolled in associate, baccalaureate and masters degree programs. Presently, recipients of scholarships must serve one year of service obligation as a full time VA employee for each year or portion of a year provided by the scholarship. A more appropriate requirement is a two year service obligation for each year of scholarship benefits. Not only will it be useful in determining the degree of commitment among the applicants, but also it aims toward retention, a major goal of the program. A two year service obligation will give participants an opportunity to develop a more viable relationship with the VA and its health care system.

Participants first year of employment with the VA can be a rewarding experience, but it is primarily an orientation and socialization process to the benefits of VA nursing practice. Often, the novice practitioner takes a full year to become comfortable in their role as a registered nurse. A second year of service obligation can act as a bridge between that time of "academic payback" and a time for "settling down". A second year can provide greater potential for more responsibility and contribute to the VA system and one's career development. Scholarship recipients already employed by the VA have demonstrated a level of commitment indicative of retention.

The VA's support for scholarship dollars is more crucial than ever as tuition and the cost of living increase annually. It is NOVA's opinion that extending the period of service obligation to two years is compatible with other Federal Scholarship Programs and will help in retention. These scholarships have resulted in over 750 nurses currently working for VA under scholarship obligation. The scholarship program enhances VA's ability to recruit qualified, registered nurses. By moving forward towards our goals, we hope to provide an environment where the new nurses will commit to a career in the VA.

Thank you for the opportunity to present this statement.

American Psychiatric Association

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TESTIMONY

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON THE

VETERANS' HEALTH CARE AMENDMENTS OF 1991

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

APRIL 10, 1991

Mr. Chairman and Members of the Subcommittee, the American Psychiatric Association, a medical specialty society representing over 37,000 psychiatrists nationwide, appreciates the opportunity to testify today on the Veterans' Health Care and Research Amendments of 1991.

Mr. Chairman, we first wish to express our gratitude and appreciation for the leadership and commitment of you and your Subcommittee to provide appropriate and necessary health care services to this country's veterans. As you know, year after year the APA has testified in support of expansion of such programs outlined in the Veterans' Health Care Amendments of 1991. This legislative initiative addresses many of the concerns that the APA has with the Administration's budget request for the VA. Therefore, the APA supports the key mental health provisions that the committee is recommending today.

The National Vietnam Veterans Readjustment Study (NVVRS) data showed that approximately 90% of the estimated 480,000 veterans with current PTSD, and 80% of the estimated 963,000 veterans with life-time PTSD, have never used VA mental health resources. This data clearly indicates that further work must be done to ascertain the extent of unmet clinical need for Vietnam theater veterans who suffer from psychiatric sequelae to war-zone stress. We should not allow the inappropriate stigma of mental illness rooted in fear to be perpetuated as a so-called cost saving measure and deny effective treatment to our veterans. The Veterans' Health Care Amendments which proposes an increase in the number of Post-Traumatic Stress Disorder (PTSD) inpatient units, clinical treatment teams, and outpatient services will provide the VA with the necessary machinations for treating those veterans who suffer from service-related mental illness. The APA is supportive of the Committee's recommendations for PTSD expansion, however, we urge the committee to recognize that there is a real need for PTSD clinical teams at every VA medical care facility.

There has been a steady erosion in the VA's ability to maintain quality psychiatric and substance abuse programming along with an inability to recruit and retain qualified psychiatrists due to the inappropriate attention and recognition under the reimbursement system and dramatic increase in the number of admissions.

A higher percentage of psychiatric patients are Service Connected or are Category A than is found with any other medical or surgical condition. However, without the passage of the Physicians Pay Bill for recruitment and retention purposes, this legislative initiative to expand services will be thwarted by an already increasing psychiatric workload.

The APA supports the committee's efforts to expand the VA program for the homeless chronically mentally ill. The VA Homeless Program does an outstanding job identifying and treating the homeless veterans nationwide. This program has the potential of reaching a vast number of the homeless population considering that anywhere between 18% to 51% are veterans.

The Homeless and Chronically Mentally Ill program found that 45% of the homeless veterans they see served in the Vietnam theater, and of these, 45% showed evidence of combat stress. These findings suggests that patients with PTSD may make up a significant proportion of the homeless, chronically mentally ill patients currently receiving treatment through the VA. The VA last year identified and provided services to thousands of veterans. While this illustrates how well the program is working, there are many more homeless veterans who would benefit from these services.

The provision of the Veterans' Health Care Amendments of 1991 which establishes a pilot program for outreach to the homeless veterans will be an effective way of identifying and bringing care to those in need -- especially to those who are mentally ill and may be unable to reach a VA facility.

The APA firmly believes that enhancing research activities will reduce costs of drugs; bring down the vacancy rate of medical personnel; and produce new concepts and mechanisms to treat and prevent disease. The APA is highly supportive of the recommendation by the committee to establish a pilot program of medical research to improve the delivery of mental health care in VA facilities as well as community-wide. This program would be beneficial to a VA facilities effort to retain and recruit psychiatrists who would be attracted to practicing at a facility that would give them the ability to conduct research.

The APA supports the committee's efforts to provide these necessary services as outlined in the Veterans' Health Care Amendments of 1991. While the APA recognizes the severe budget constraints that the committee must work within, we encourage the committee to provide the critically needed funding for VA medical care and health research. These proposed expansions and new programs would be extremely beneficial to veterans with mental illness if fully funded.

The Amercian Psychiatric Association appreciates the opportunity you have afforded us to present our support of the Veterans' Health Care Amendments of 1991.

Association of Professors of Medicine

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STATEMENT

of the

ASSOCIATION OF PROFESSORS OF MEDICINE

on

The Veterans' Health Care and Research Amendments of 1991

submitted to

Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
U.S. House of Representatives
April 10, 1991

Mr. Chairman and Members of the Subcommittee:

The Association of Professors of Medicine (APM) appreciates the opportunity to comment on the Veterans' Health Care and Research Amendments of 1991. As chairs of departments of internal medicine at the 126 US medical schools, matters concerning the VA health care enterprise, particularly as they relate to the medical care and research missions, are of paramount concern to the APM. At those 103 medical schools that are formally affiliated with a local VA Medical Center, nearly two-thirds of the faculty of the departments of internal medicine have joint appointments between the two institutions. In addition, investigators in these departments receive the majority of the funding from the VA research program. Clearly, the members of the APM and their faculty have a large stake in the continued vitality of the VA health care enterprise.

The legislation before the subcommittee today covers a wide range of issues related to the VA health care system, many of which are of only tangential interest to the APM. The Association's testimony will be limited to the sections of the bill that concern the establishment of a pilot program for VA research, and the granting of authority to the Chief Medical Director to establish standards for VA laboratory facilities.

As stated in the outline of the legislation provided to the APM prior to the hearing, the pilot program in VA research would be established in the following manner:

> Require, subject to the availability of appropriations, the establishment of a pilot program of medical research to improve the provision of medical care in VA facilities. The bill would call for the Secretary of veterans affairs to solicit proposals from VA medical centers for the conduct of research applicable to clinical care in the areas of 1) mental illness, 2) alcohol and substance abuse, and 3) neurologic, psychiatric, and geriatric rehabilitation. To be eligible for such funding, a medical center must have entered into an agreement with a medical school...that agrees to provide partial funding or in-kind support for the proposed research...among those proposals deemed meritorious under a peer review process, the Secretary must give priority to those proposals deemed to offer the greatest contribution to improving the quality of clinical care.

The APM is pleased that earlier this year, the full Veterans Affairs Committee recommended a budget for the VA research program of $260 million for FY 1992. The Subcommittee is well aware of the excellence of this program, and Chairman Montgomery has been one of Congress' leading advocates providing more appropriate levels of funding for the program. The Subcommittee is also aware of the chronic underfunding that has plagued VA research for the past six years, and the negative impact this has had on staff morale and the recruitment and retention of highly qualified physicians at the VA. The APM is an active member of the Friends of VA Medical Care and Health Research coalition, and will be working through the appropriations process to try to secure the maximum level of support for the VA research program.

The three area of research which would be targeted for the pilot program under the bill are certainly ones which have a significant impact on the VA patient population, as well as areas where the VA has been a leader in on-going research efforts. Particularly in the area of geriatrics, the rapid aging of the VA patient population makes it an ideal location for increased research into both the medical problems that afflict older veterans, and the manner in which such services are delivered.

The single element most responsible for the success and achievement of research funded by the federal government in the last 45 years -- be it by the National Institutes of Health, the National Science Foundation, or the VA -- has been the reliance on the awarding of grants based on scientific excellence determined through peer review. This becomes especially important in an era of limited dollars available for research. The Subcommittee is well aware of this from testimony given by the APM and other organizations during a hearing on the VA research program in October, 1989.

The bill calls for the applications in the pilot program undergo peer review, and the APM assumes this means the same peer review process as all other VA research applications, not a separate section for the research targeted for the pilot program. The APM is confident that if the appropriations process produces an increase in VA research funds of $43 million (the threshold in the bill for the initiation of the pilot program), that the regular review system would produce at least $6 million in grants for research into the areas detailed in the bill. However, given the importance of these areas of research to the care of the VA patient population, the APM believes the special emphasis of the pilot program is warranted. The APM cautions, though, that the Subcommittee not position itself such that it will have to respond to calls for more emphasis on particular areas of research. To do so would destroy the VA research effort.

In order to make maximum use of the pilot program, the APM suggests that language be included in either the final legislation or the report asking that the VA consider using the pilot program to build upon existing research in these areas, with the aim of building centers of excellence at certain VA medical centers.

In sum, the Association welcomes the Committee's emphasis of the close link between the VA research program and the provision of top quality clinical care services for VA patients. While generally the APM believes that mandating of a certain level of spending on a specific area of research is unwarranted, we feel that mental illness, alcohol and substance abuse, and neurological, psychiatric and geriatric rehabilitation are of critical importance to a significant number of current VA patients to warrant increased attention. However, application for grants under this program must undergo the same rigorous peer review process as all other VA research projects. Further, we urge that these funds be used as seed capital to build centers of research excellence in these areas.

The second section of the draft legislation of concern to the APM is stated in the outline as follows:

> Clarify that, not withstanding any other law, the Chief Medical Director has exclusive authority to set standards for, and assure consistent performance of, VA laboratory facilities.

As the Subcommittee is aware, Congress in 1988 passed the Clinical Laboratory Improvement Act (CLIA). This was, in the main, a response to concerns that laboratories performing tests whose results will be reported to patients meet standards for safety and quality assurance. All laboratories, except those engaged exclusively in research, are covered under the law.

The Health Care Financing Administration (HCFA) of the Department of Health and Human Services last issued proposed regulations to implement the CLIA law. This proposal generated over 10,000 comments, ranging from individual physicians practitioners to large, hospital-based clinical pathology laboratories. The myriad of comments received by HCFA has led them to undertake a substantial revision of the proposed CLIA regulations -- a process that is still on-going, we believe.

Providing the highest quality health care services to veterans is the aim of all those who advocate on behalf of the VA. In the view of the APM, this extends to assuring the quality of all services performed in VA laboratories. The Association is sure that the Subcommittee's intent is not to try to lower the standards that must be met by VA laboratories; we are concerned, however, as to the perception that may arise from exempting the VA from the CLIA regulations, as well as other federal laboratory rules such as those governing the use of animals, human subjects, and fetal tissue in research. There must be no doubt in the minds of VA patients or the public at large as to the quality of the services delivered in VA facilities.

Another area of concern is the impact that the exemption would have on certain laboratories in which space is shared between a VA medical center and a department from an affiliated medical school. It seems as though confusion would arise in these situations as to whether CLIA or any other federal laboratory standard applies, or whether the facility is exempt under the provision in the bill. An unintended consequence of the provision could be making sharing agreements between the VA and its medical school partners more difficult to implement.

The APM would be interested in working with the subcommittee to identify specific concerns about the impact of current or pending federal regulations on VA laboratory facilities We do not, however, believe that a blanket exemption from current laboratory regulations for the VA is a appropriate response to such considerations.

Once again, the APM thanks Chairman Montgomery and the members of the Subcommittee for it support of the VA medical enterprise, and for the opportunity to comment on this legislation. Please call on us when we can be of assistance.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

JUN 12 1991

The Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Enclosed please find the Department's responses to the follow-up questions which you and Congressman John Paul Hammerschmidt forwarded following the April 10, 1991, hearing of the Subcommittee on Hospitals and Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely yours,

Edward J. Derwinski

Enclosure
EJD/flc

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

QUESTIONS OF CHAIRMAN MONTGOMERY

Question: 1. Please identify the reasons that might prompt VA to sell its interest in "jointly procured" medical equipment? Is the draft bill incomplete to the extent that it does not provide for VA to buy its "sharing" partner's interest in a piece of equipment? If so, please provide, as a technical service, draft language to accomplish this? Also, please clarify for the record the reasons why it might be desirable from VA's standpoint to site equipment procured under this proposal at the sharing partner's facility rather than at the VA medical center.

Answer: Reasons which might prompt VA either to acquire or divest itself of interest in jointly procured advanced technology equipment resources:

Obsolescence of either equipment technology or of diagnostic/therapeutic methodology; change of mission at a given VAMC; persistent heavy increase in work/patient load sufficient to require solely owned equipment/space/staff capabilities: failure of sharing partner to live up to the terms of the agreement.

By letter dated April 19, 1991, the VA General Counsel provided the requested draft language as a technical service (see attached).

Reasons which make preferable the siting of certain advanced technology equipment at the sharing partner's facility rather than at the VAMC:

Requirement for special construction, extensive site preparation, and utilities to accommodate advanced technology facilities.

Requirement for additional specially trained professional and support staff to operate the equipment/facility.

Unavailability of site preparation or construction funds.

Unavailability of personal service funds for VAMC to operate equipment.

Question: 2. Would it be practical for VA to use the shared procurement idea in our proposed legislation to acquire computers to support enhanced clinical applications like the medical imaging we saw during this hearing? If so, would provisions of the draft bill permit it, in your view? If such an idea were practical but could not be accomplished under the bill's provisions, please provide us, as a technical service, language which would permit such procurements.

Answer: Although the shared procurement and joint title concept is advantageous to the VA under a number of circumstances, we do not believe that it would be practical to use it for the procurement and ownership of computers needed to support the VA DHCP Integrated Imaging System. This is because the VA's Imaging System has several characteristics that make it different from typical vendor-provided medical equipment. First, the DHCP Imaging System is not a stand-alone system but is an integral part of the VA's DHCP Hospital Information System which supports many departments throughout the medical centers. Therefore, another health care institution using the Imaging System would also have to be using the DHCP hospital information system to obtain its full benefits. Second, the DHCP system has been designed to meet the VA's needs, and might require modification to fit the structure of a private health care provider. The VA could find itself in a position where its staff of resources were diverted away from the needs of our veterans. Third, the software of the DHCP system and the Imaging System is developed, maintained and supported by government employees working for the VA. The VA normally distributes software to non-VA users on an unsupported basis (public domain). If a system were installed in a non-VA facility, an arrangement for the VA to provide system support could become a significant logistical and administrative problem. Finally, the VA implements the same software in its medical centers across the country to provide uniform patient care support services, consistent data collection and consolidated administrative reporting. This requires coordinated organizational planning that results in cost-effective equipment procurement based on nationwide purchasing. A shared procurement and joint title strategy for ADP equipment on a site-by-site basis would undermine this approach.

Question: 3. In administering its advanced medical technology/shared use program, medical centers which have "won" competitions for VA Central Office funding support have reportedly failed - in some instances - to work out with their "sharing partner" details of management and staffing responsibilities in advance of equipment installation, resulting in delays and confusion in delivery of care.

What, if any, safeguards are in place or will you put in place to prevent this from occurring in the future?

Answer: We are developing safeguards to ensure that VA facilities and their staffing partners agree on management and staffing responsibilities before equipment installation.

Question: Are you satisfied that the selection process which evaluates shared equipment procurement proposals can assure that VA receives equitable access given its investment in purchase of the advanced technology equipment? If so, why? If not, please advise how the selection process might be "fine-tuned" to promote greater assurance of equitable access.

Answer: Assurance of equitable access to equipment facilities is a primary requirement of the sharing agreement which permits the sharing partner to use VA's equipment. Experience to date indicates this has not, in any way, been a problem.

Question: 4. In evaluating VA medical center proposals for procurement and shared use of advanced technology equipment items, to what extent have patient demographics and projected workload been significant factors in the selection process?

Should the selection process take into account whether the equipment and related services under consideration for procurement are being, and could continue to be, provided to the patient population in question by a nearby VA medical center? Is consideration currently being given to such a provision and if not, why not?

Answer: Patient demographics and projected workload are two of the primary criteria considered by the evaluation team in judging need, appropriateness to mission, and productivity factors relative to resources which the proposed joint arrangement would make available.

The selection process does include assessment of the availability of the desired capability from other VAMCs. Such consideration does factor costs, delivery time and its criticality to patient care, and mission relationships, among others to rank order proposals for final approval.

Question: 5. Current law calls for VA research corporations to obtain tax exempt status. Can you explain the apparent problem some of these corporations have had with the Internal Revenue Service?

Answer: VA research corporations must have tax exempt status under 26 U.S.C. § 501(c)(3). That law requires that such corporations be organized and "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes." Implementing Internal Revenue Service (IRS) regulations require that such organizations establish that they are not organized or operated for the benefit of private interests, or directly or indirectly controlled by private interests. IRS has yet to determine whether VA research corporations performing research under grants or funds from drug corporations meet this requirement. The IRS has expressed concern about commercial drug firms funding research corporation activity. IRS suggests that research thus funded primarily serves the private interests of drug companies funding the research.

We have advised IRS that, in our view, VA research corporations operating under Public Law No. 100-322 qualify for tax exempt status under section 501(c)(3), even when performing drug company funded research. We understand that IRS' Central Office will shortly issue a ruling resolving this question in a case involving a request for tax exempt status for a Kentucky VA research corporation.

Question: 6. How much of the Departments FY 1991 research budget went to research efforts in the areas targeted by our proposed legislation?

Answer: Fiscal Year 1991 information will not be available until the end of the Fiscal Year. The expenditures for Fiscal Year 1991 should not be significantly different than those reported for FY 1990 listed below:

Areas	$(000)
Mental Health	$19,415,263
Alcoholism & Substance Abuse*	$11,468,462
Rehabilitation (Neurological, Psychiatric & Geriatric)	$ 3,941,639

(*includes tobacco)

Question: 7. How would a provision exempting VA from CLIA apply in the case of a clinical laboratory in which space is shared by a VA medical center and an affiliated medical school?

Answer: The answer to this question rests on who owns the property in which the shared laboratory is located. If the shared lab is in a VAMC, the lab would be exempt. If the lab is in the physical confines of the private sector, then the lab would be subject to CLIA regulations.

Question: 8. In VA testimony during the April 10 hearing, reference was made to discussions with HHS officials on coming to agreement on exempting VA from the Clinical Laboratory Improvement Act's regulations. When did these discussions begin, and what agreements have been reached so far?

Answer: The first discussions began in March 1991 as VA was drafting its testimony for the April 10 HVAC hearings. Subsequently, it was agreed that there should be a joint meeting of VA, HHS and DoD to resolve major issues that CLIA has raised regarding federal laboratory regulation under CLIA '88. DoD has also drafted similar legislation requesting an exemption, and is expected to make the initial contact with HHS to set up the joint meeting, if it has not already done so, in the near future.

Question: 9. Please explain why VA believes the use of so-called "enhanced use" agreements may be the most cost-effective method by which VA could obtain child care services?

Answer: The Department does not intend that the enhanced use proposal be the sole solution to VA employees' child care requirements. In many instances, renovation or construction of new space and contracts for services will be the more cost-effective and attractive alternative. The Department believes that a multi-faceted approach has the greatest potential for success.

An enhanced use child care project can be more cost-effective than alternative methods in certain circumstances. Enhanced use development is likely to be most successful in situations where: (1) the requirements of service delivery are clear and easily defined; (2) there is an existing industry with adequate competition; (3) the requirement is long-term, thus allowing the private developer sufficient time to amortize investments; and (4) there is available land for development. VA facilities with a requirement for a child care center exhibiting these circumstances would be excellent candidates for enhanced use agreements.

The Department envisions the following potential savings, depending upon location and VA requirements, where enhanced use agreements are used to obtain child care centers:

- Faster construction/activation -- With private sector financing, a lengthy Federal Budget process is avoided; with private sector construction, a simplified Federal construction approval process is achieved due to transfer of construction risk to private sector and significant local oversight;
- Use of "off-the-shelf" private sector designs and criteria -- This results in cost and time savings since new designs need not be drawn; child care providers' "off the shelf" designs meet state and local standards; solicitation is structured to obtain the best design; and
- Competiton for experts in child care -- Allows VA to focus on the primary mission of service to veterans rather than expend resources to gain expertise in the design and construction of child care centers; this competition also will generate the most cost-effective quality product.

Past Federal and private experience in public/private ventures has shown that there is a considerable cost variation between government and commercial construction. The merit of attempting the "enhanced use" approach is illustrated by the fact that today many hospitals and other agencies are looking to these types of ventures to meet their requirement for child care.

Question: 10. VA plans to raise its educational requirements for newly hired social workers by requiring that they have master's degrees.

How will the requirement of a masters degree affect recruitment and retention of social workers at VA medical centers? Will VA be limiting the pool of applicants by instituting this requirement?

Answer: VA does not plan to change the educational requirements for social workers. A master's degree in social work has been required since the 1940's or early 1950's. The VA proposal is to require licensure, certification or registration of Social Workers. This is not expected to affect recruitment and retention of qualified staff or to limit the pool of applicants.

Forty-eight of the fifty states, the District of Columbia, the Virgin Islands, and Puerto Rico regulate the practice of clinical social work. The remaining states have some level of legislative activity currently in process regarding the licensing of social workers. Mandatory licensure for VA social workers is essential to provide assurance to the public that professional social workers in the VA have parity with their non-Federal counterparts.

A survey completed during the 1st part of FY 87 found that 78% of all social workers employed by the VA were either currently licensed or in the process of meeting licensure requirements.

Question: What percent of social workers at Vet Centers currently have master's degrees? How will this affect recruitment efforts and the staff mix at Vet Centers?

Answer: All vet center social workers have master's degrees, so the new requirement will have no impact as such.

QUESTIONS SUBMITTED BY HONORABLE JOHN PAUL HAMMERSCHMIDT
TO THE DEPARTMENT OF VETERANS AFFAIRS
AT THE SUBCOMMITTEE ON HOSPITALS & HEALTH CARE
APRIL 10, 1991
DRAFT LEGISLATION

Question: 1. Has VA's position on extension of authority to provide care in the Philippines been coordinated with other executive departments, such as state and defense?

Answer: Yes. The Office of Management and Budget has coordinated our position with those Departments.

Question: 2. With respect to raising the threshold for second opinions on fee basis dental care, how much does VA estimate would be saved?

Answer: Annually, approximately 8,000 veteran beneficiaries are required to receive a second opinion clinical examination for fee dental cases exceeding $500. It is estimated that amending Title 38, as proposed, would require a second examination for approximately 1,000 veterans on an annual basis. This action would result in a cost savings to the VA of approximately $770,000 over the next five years. Not only would a cost savings be realized by the veterans and the VA, but our dental staff could direct the time spent on this program toward treatment of high priority patients.